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***Containing Contradictions:
the development of prison drugs policy in England since 1980***

**A thesis submitted to Middlesex University in partial fulfilment of the
requirements for the degree of Doctor of Philosophy**

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December 1999

Abstract

This thesis is a study of policy networks in the development of prison drugs policy in England during the late twentieth century. Drawing on semi-structured interviews with key actors in the policy process, including civil servants and representatives from drug agencies, penal reform groups and professional associations, and an analysis of documentary materials, it examines the role and influence of policy networks in policy development. The thesis is multi-disciplinary in its approach, drawing on concepts, theories and research from a variety of disciplines including criminology, social policy, sociology, political science and public administration.

The analysis is based upon the construction of a series of four case studies which correspond to the key phases in prison drugs policy development since 1980: 1980-1986; 1986-1993; 1993-1997; and 1997-. It explores policy development around drug treatment and throughcare, HIV/AIDS and drug misuse, supply reduction activities and security and control measures. The development of policy has hinged upon complex patterns of conflict, contradiction and convergence between treatment and punishment. Throughout the phases, particular policy networks have evolved around drug-related issues within the penal system, expanding and becoming more complex in their structure and operation over time. They have attempted to contain, balance and negotiate the contradictions within policies. This 'balancing act' or 'containment' has taken many different forms and has been shaped by several processes or forces: the way in which the drug problem has been framed and defined; the role of research, evidence and knowledge; and the impact of wider social, political, policy and institutional contexts.

The conclusions of the thesis are: first, as prison drugs policy became more explicit and defined, the contradiction between treatment and punishment became more acute; second, the shift towards a more explicit policy was shaped by the activities of the policy networks, which in turn were influenced by changes in the drug problem, the role of research, and changes within the wider social, political, policy and institutional contexts; third, the role and power of the policy networks has varied over the different phases of policy development; fourth, in the process of engaging in policy development and attempting to contain the contradictions between treatment and punishment, the policy network around drug issues in prisons has changed shape with key players becoming incorporated by the state.

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List of Abbreviations

ACMD	Advisory Council on the Misuse of Drugs
ACPO	Association of Chief Officers of Police
ACOP	Association of Chief Officers of Probation
ADFAM	The national charity for the families and friends of drug users
ADSS	Association of Directors of Social Services
AIDS	Acquired Immune Deficiency Syndrome
CARAT(s)	Counselling, Assessment, Referral, Advice, and Throughcare Service
CCTV	Closed circuit television
CDCU	Central Drugs Co-ordination Unit
CDPU	Central Drugs Prevention Unit
CFI	Central Funding Initiative
DARI	Drug Addiction Research Initiative
DAT	Drug Action Team
DDAC	District Drug Advisory Committee
DHA	District Health Authority
DH	Department of Health
DPAS	Drugs Prevention and Advisory Service
DPI	Drugs Prevention Initiative
DRG	Drug Reference Group
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HMP	HM Prison
ISDD	Institute for the Study of Drug Dependence
KPI	Key performance indicator
LGDF	Local Government Drugs Forum
LDPF	London Drug Policy Forum
MDT	Mandatory drug testing
NACRO	National Association for the Care and Resettlement of Offenders
NAPO	National Association of Probation Officers
NHS	National Health Service
PGA	Prison Governors' Association
POA	Prison Officers' Association
PRS	Parole Release Scheme
PRT	Prison Reform Trust
RAP	Radical Alternatives to Prison
RAPt	Rehabilitation for Addicted Prisoners Trust
SCODA	Standing Conference on Drug Abuse
TDT	Tackling Drugs Together
UKADCU	UK Anti-Drugs Co-ordination Unit
VIR	Viral Infectivity Restrictions
VTU	Voluntary Testing Unit
WHO	World Health Organisation
WIP	Women in Prison

Preface

This thesis is concerned with the development of prison drugs policy in contemporary England.¹ The drug issue in prisons is a world-wide phenomenon and has become a policy concern in many countries. Drugs² have become an integral part of the discourses around crime, punishment and prisons. During the 1990s, the proportion of male and female prisoners serving sentences for drugs or drugs-related offences increased steadily in Britain (Home Office Statistical Bulletins, 1993; 1995; 1996a; 1997b; 1998). A significant number of prisoners also suffer from drugs-related problems such as addiction (Home Office Statistical Bulletin, 1997a), withdrawal and unsafe injecting practices during their sentences (Strang et al, 1998). Drugs are in great demand within the prison environment due to the number of existing drug addicts and also because they are a means of escaping from the deprivations of prison life.

Official interest in drug issues within the penal system is relatively recent, with formal policy only beginning to develop in the mid-1990s. Over the last decade, there has been an increasing emphasis on the interface between drug and penal policy. In 1995, the prison system was included in national drugs policy for the first time. The interest in this area has emerged from a variety of different perspectives including the Department of Health in the Task Force report on the review of services for drug misusers (Department of Health, 1996); the Prison Service in its strategies to tackle drug misuse in prison (HM

¹This study is restricted to England rather than the United Kingdom as a whole for two main reasons. Firstly, there are separate prison systems for England and Wales, Scotland, and Northern Ireland. The various systems have different rules, laws and policies. Secondly, there are separate national drugs policy frameworks for England, Wales, Scotland and Northern Ireland.

² The primary concern of this thesis is *illegal* drugs or those 'designated illegal for purposes of possession or use or trade according to various domestic laws and international agreements and treaties' (South, 1997: 925). The Misuse of Drugs Act 1971 places controlled drugs in three classes: Class A, B, and C. Offences involving those in Class A (ie. heroin and other strong opiates, cocaine, LSD, and Ecstasy (MDMA)) attract the highest penalties (up to life imprisonment for production and supply). The same offences for Class B drugs (ie. cannabis, amphetamines, and barbiturates) attract maximum penalties of 14 years and for Class C drugs (ie. tranquillisers, mild stimulants, anabolic steroids) attract five years. Offences involving possession attract lesser maximum penalties. (ISDD, 1996: 15). 'Drug misuse' is defined as the non-medical use of drugs that are only intended for use in medical treatment, and the use of drugs that have no accepted medical purpose.' (HM Government, 1994: 15).

Prison Service, 1995a; 1998b); the former Conservative and current Labour governments in their national drugs strategies (HM Government, 1995; 1998b); the Advisory Council on the Misuse of Drugs in their report on drug misusers and the prison system (ACMD, 1996); various voluntary agencies working with and on behalf of prisoners and drug misusers in prisons; and the media. Increasing amounts of government expenditure have also been directed at the prison drugs 'problem'. For example, during 1996-1997, £4.2 million was made available to cover the costs of implementing mandatory drug testing which was introduced across the prison system in Spring 1996 (Penal Affairs Consortium, 1996). For the three years commencing 1999/2000, the Prison Service is to receive an additional £76 million to fund a new framework for drug treatment within the prison system (DPAS, 1999).

Policies and initiatives must be viewed as not just a reaction to the current situation, but as historically and culturally framed. There has been a long history of debate regarding the locus of responsibility for the social control of drug misuse. British scholars have generally concluded that policy has been shaped by an accommodation between medical and criminal justice concerns (see Berridge, 1978, 1996b; Smart, 1984a; Stimson, 1987a; Pearson, 1991; Dorn and South, 1994; MacGregor, 1998a). As Smart (1984a: 31) has argued, 'the drug user is in the unique, although unenviable position of occupying the locus of attention of several different modes of regulation; legal, moral and medical. Whilst these analytically distinct modes overlap in their concentration on the drug user, they are also frequently in conflict'. Analyses of drugs policy indicate a balancing act between medical and penal forms of control or between treatment and punishment. This balance has changed over time and is influenced by the nature of addiction or the drugs 'problem' as well as the social, political and institutional contexts. Within policy there is an enduring tension between 'whether the addict is to be termed sick and a fit subject for medicine, or bad, and a subject for penal control' (Berridge, 1996b: 302). It is evident that the tensions and contradictions between medical and penal forms of control manifest themselves in their most acute form within prison drugs policy.

Although the position is changing rapidly as more research on the interface between drugs and criminal justice is conducted, various scholars have argued that the

criminological approach to drug issues has not been particularly well developed in Britain (see Downes, 1988; Pearson, 1990; 1992a; South, 1994). This is a consequence of the domination of the medical-disease model of addiction and the clinical and medical origins of British drugs policy (Berridge, 1990; Pearson, 1990). It also reflects the large proportion of addict cases which were either 'therapeutic' or 'professional'³ in origin prior to the 1960s. British research has tended to focus on epidemiological issues, treatment and services. This historical context led to a lack of research and understanding of the relationship between drugs and crime and the position of drug misusers within the criminal justice system. There is also a paucity of research on the processes involved in the development of both drugs and penal policy, with neither scholars of criminology nor public administration focusing on the policy process itself as a subject of concern. In particular, there has been no research examining policy development in the areas of drugs and prisons. This lack of research highlighted the need to trace contemporary origins of the 'problem' of drugs in prison and to explore the processes involved in the development of policy.

This thesis is a case study of the development of prison drugs policy from 1980, involving documentary analysis and interviews with key policy players including civil servants, directors of drug agencies and penal reform groups, and spokespersons from professional associations. It explores policy development through the prism of the 'policy network'. The policy network approach has become one of the dominant approaches to studying policy-making (Dowding, 1995), but has never been applied in analyses of penal policy, and rarely been applied in analyses of drugs policy. In relation to prison drugs policy, important questions which needed to be addressed were: why did policy begin to develop, why did it develop in a particular way, who was involved in this development, and how did they shape policy outcomes? Within this policy analysis, a multi-disciplinary approach has been adopted, drawing on concepts, theories and research from a variety of disciplines including social policy, criminology, sociology, political science and public administration.

³ Therapeutic addicts refer to those who became addicted as a result of treatment for illness and who continued to be addicted after their illness ended. Professional addicts refer to those who were medically connected (Berridge, 1999: 281).

The research has four key objectives. The first is to critically review and analyse the development of prison drugs policy since 1980, with a focus on the 1995 prison drugs strategy. The second objective is to apply concepts and constructs from the policy sciences to the study of prison drugs policy. The third is to explore the role and influence of policy networks in policy development. The final objective is to examine the conflicts and contradictory pressures in the development of prison drugs policy. In particular, the analysis will focus on how policy networks have attempted to contain the contradiction between treatment and punishment and how their activities have been shaped by a) the way in which the drug issue in prison is defined and framed; b) the roles of research, evidence and knowledge in the policy process and c) the impact of the wider social, political, policy and institutional contexts. The principal research questions to be addressed are therefore as follows:

How influential have the policy networks around drug issues in prison been in the development of policy? When have they been most influential and why?

How have these networks attempted to contain the contradiction between treatment and punishment in policy development?

How has this 'containment' been shaped by changes in the way in which the drug problem has been framed and defined, new research, evidence and forms of knowledge, and the impact of wider political, policy, social and institutional contexts?

One of the key difficulties in researching the contemporary policy process is that it is continually developing and expanding. This causes problems for researchers in terms of choosing a cut-off point for their analyses. Moreover, as policies evolve and time passes, interpretations and analyses often develop and change (Berridge, 1994). I experienced these difficulties in my analysis of the development of prison drugs policy. The analysis is restricted mainly to the period from 1980 to 1998. The study begins in 1980 because this year marked the first formal documented interest in drug issues in prison with the publication of the first ACMD report on drug dependants within the penal system (ACMD, 1980). The main focus of the research revolves around the 1995 prison drugs

strategy which involved fundamental shifts and changes in the way that drugs were dealt with in prisons. My analysis ends in 1998 which marked the reformulation of the 1995 strategy. Through my analysis of the main policy documents and interviews with key policy actors, it became clear that the development of prison drugs policy could be divided into four main phases: 1980-1986; 1986-1993; 1993-1997 and 1997-. At the time of writing, the last phase continues to evolve and develop.

This thesis consists of seven chapters. Chapter One explores the existing literature in the areas of drug and penal policy and identifies the key questions, concepts and themes which will run through my analysis of the interface between these two areas. Chapter Two discusses the research design and processes involved in the study. It begins by exploring the political dimension of the research problem and then describes and justifies the type of approach, methods of data collection and analyses which were employed. The final section of the chapter presents a reflexive account of my experiences of undertaking the research.

Chapters Three, Four, Five and Six deal with the phases of prison drugs policy development chronologically. Because the policy process is fluid, I have tried to avoid a rigid demarcation between the phases. In order to illustrate this fluidity, the phases overlap with Chapter Three focusing on the period from 1980 to 1986, Chapter Four on 1986 to 1993, and Chapter Five on 1993 to 1997. Chapter Six deals with developments from mid-1997 which were still evolving at the time of writing. Each of these chapters broadly conforms to the same pattern. They begin by introducing the particular phase of policy development and highlighting the main features of the period. This is followed by a brief discussion of the drugs and penal policy contexts during the particular phase. The chapters then explore how the 'problem' of drugs in prison was defined and framed. This is followed by an analysis of the policy response to the drugs 'problem' in prisons during the period under review. The chapters draw upon the key policy documents, reports and relevant research, as well as data generated through the interviews conducted with key players in the policy process.

Chapter Seven reflects on the analysis of developments in the various phases by re-

visiting the questions, concepts, and theories outlined in Chapter One. This chapter concludes by exploring the significance of my findings for the future development of prison drugs policy.

Chapter One

Making sense of the development of prison drugs policy: key literature, concepts and theories

Introduction

In this chapter, I review and analyse the existing literature in the areas of drugs and prisons, particularly in relation to policy development in Britain. Until the late 1990s, drug issues in the prison system attracted very little research attention. The studies which have been conducted have focused mainly on the nature and extent of drug misuse amongst prison populations and include evaluations of recent policy initiatives. There has been no systematic research on the processes involved in the development of prison drugs policy. I have therefore explored general analyses of drugs and penal policy development in order to identify key questions, concepts, and themes which will be relevant to my analysis of the interface between these two areas of policy. Having identified the central questions to be addressed, the final part of the chapter develops these into a conceptual framework to guide and frame my analysis of prison drugs policy development from 1980.

Research on drug issues in prison

Despite increasing interest in the issue of drug misuse and its relationship to the prison system since the 1980s, this area has attracted very little scholarship. Research on drug issues and policy in prisons can currently be described as going through a phase of 'catching up'. Until the early 1990s, researchers had been repeatedly denied access to undertake such research.¹ This was mainly due to the reluctance of politicians,

¹The difficulties in gaining access to conduct research in prisons has been an enduring feature within the British prison system. See for example Stan Cohen and Laurie Taylor's accounts of their battles with the Home Office over access and censorship in their research on the experience of long-term imprisonment at Durham prison in the late 1960s and early 1970s (Cohen and Taylor, 1972; 1975; 1977).

government officials and prison governors to publicly acknowledge that there was a drugs 'problem' or the fact that drugs were being used within the prison system. The research which was eventually conducted in this area was primarily concerned with prevalence issues (see Maden et al, 1990; 1991; 1992; Bridgwood and Malbon, 1995) and the patterns of drug misuse and HIV risk behaviour in prison populations (see Stimson et al, 1988; Donoghoe et al, 1989; Dolan et al, 1990; 1991; Carvell and Hart, 1990; Dye and Issacs, 1991; Kennedy et al, 1991; Turnbull et al, 1991; 1994; Bird et al, 1992; 1993; Power et al, 1992; Covell et al, 1993; Keene, 1997b; Strang et al, 1998; Swann and James, 1998; Cope, 1999). These studies have highlighted the extent of drug misuse prior to and during imprisonment, the problems and risks associated with continued misuse and the lack of treatment services within the prison system. With the exception of the drug treatment programme at HMP Downview (see Player and Martin, 1996; Bond, 1998; Kinchin, 1998), the few treatment initiatives which did exist in the British prison system prior to 1995 have not been independently evaluated. In contrast, emanating from the United States and reflecting the greater historical emphasis placed on the criminal justice system as an arena for drug treatment in that country, there is a large body of North American literature assessing the effectiveness of various prison-based drug treatment programmes (see for example, Field, 1985; 1989; Wexler et al, 1986; 1990; 1991; 1993; Anglin and Hser, 1990; Leukefeld and Tims (eds), 1992; Wellisch et al, 1993; Peters, 1993; Inciardi, 1997).

With the implementation of the 1995 prison drugs strategy in England and Wales and the more open acknowledgement of the drugs 'problem' in prisons, there now appears to be greater willingness to allow limited access to researchers to undertake research and evaluations. The Prison Service commissioned its own evaluation research to examine the effectiveness of particular aspects of the 1995 strategy.² Several independent studies

²This includes an evaluation of the pilot drug treatment programmes conducted by PDM Consulting (PDM Consulting Ltd, 1998), a quantitative study of the trends in MDT (mandatory drug testing) conducted by the National Addiction Centre (Farrell et al, 1998), a qualitative study exploring the impact of MDT conducted by the Oxford Centre of Criminological Research (Edgar and O'Donnell, 1998a; 1998b) and a study of drugs-related knowledge and training needs of prison staff conducted by Leicester University (Hucklesby et al, 1999).

concerned with the impact of the policy in individual prisons have also been conducted.³ Although much of the research has been policy-related and provided some critique of the strategy, the dynamics of the policy process itself and overall policy development have not been central within these analyses. Given the nature of existing and current research on drug issues in prisons, it was evident that there was a need to conduct independent research with an academic and theoretical orientation on the contemporary development of prison drugs policy, locating this process within a wider social, political and policy context. Analyses of the development of drugs and penal policy provide a useful backdrop for such an analysis, highlighting important themes, concepts and issues.

Analyses of drugs policy

The existing literature on the development of British drugs policy has tended to concentrate on opiates and the so-called 'British system' of drug control. Various commentators working within different disciplines have provided overviews of British policy (see for example Schur, 1963; Lindesmith, 1965; Stimson and Oppenheimer, 1982; Trebach, 1983; Smart, 1984a; MacGregor (ed), 1989; Pearson, 1991; Strang and Gossop (eds), 1994; Coomber (ed), 1998; Berridge, 1999). The methods used to analyse policy development can be broadly categorised as sociological, social-historical, social policy analysis, investigative journalism or informed comments from practitioners or clinicians working in the field (Stimson, 1990a). Very few analyses have been conducted which focus on the dynamics of policy-making or the policy process itself. In 1982, the Social Science Research Council concluded that there had been 'very few British studies on the genesis of overall national responses to drugs, alcohol or tobacco and few studies directed to policies on any more particular topic' (SSRC, 1982). Similarly, the Drug Addiction Research Initiative (1990) concluded that there had been little substantive

³These studies include an evaluation of the effectiveness of the 1995 prison drugs strategy in a local prison (MacDonald, 1997), a qualitative study of staff and prisoners in a local prison (Keene, 1997a), a survey of prison Heads of Custody exploring the control aspects of the strategy (Seddon, 1996), an evaluation of a prison-based throughcare project in HMP Liverpool (Mair and Barton, 1998), and quantitative research on the mandatory drug testing (MDT) procedures (Gore et al, 1996; Bird et al, 1997).

research on the development of national drugs policy and few studies of particular policy areas. Since these reports, research addressing the formation of drugs policy and the character of policy-making has remained underdeveloped⁴.

British drugs policy is often divided into four broad phases of development for analysis (see Stimson and Oppenheimer, 1982; MacGregor, 1989b; Pearson, 1991; Berridge, 1999). The first phase during the nineteenth century was characterised by increasing controls on the sale of opium. In the most detailed and comprehensive account of this early period⁵, Virginia Berridge (1999) has traced how attitudes and perceptions towards opium use changed and the subsequent shifts in the control and regulation of the drug. The position shifted from one of free availability towards greater pharmaceutical and medical regulation. She argues that public health concerns about the dangers of urban opiate use increased during the industrial revolution and centred upon 'infant doping' and 'luxurious use' amongst the working class despite widespread patterns of use amongst the middle classes (Berridge, 1999: 97). Under the Pharmacy Act of 1868, the sale of opium was restricted to pharmacists and prohibited in general stores, grocers and market stalls. Although in practice the Act had little impact on restricting use, it was significant as it 'established, at first albeit partially, that opium was a professional matter and that it must indeed be subject to some form of control' (Berridge, 1999:122).

During the last quarter of the nineteenth century, attempts were made by the medical profession to construct habitual drug misuse as a 'disease' whereby certain misusers - mainly middle class addicts - were classified as 'sick' or 'deviant' (Berridge, 1999). By the outbreak of the First World War, Stimson and Oppenheimer (1982:23) argue that two views regarding opiate use had emerged. The first saw addiction as a medical

⁴This research area is also relatively underdeveloped in the United States. Although there is a body of literature which provides commentary on drugs policy, little substantive research has been conducted on policy development. However, there are exceptions including Meier's work on drugs and alcohol policy which explores the role of political, citizen, industry and bureaucratic forces in policy development (Meier, 1992; 1994) and Sharp's work on agenda-setting processes during three drugs policy episodes under the Nixon, Carter, and Reagan administrations (Sharp, 1992).

⁵Other accounts have also focused on the nineteenth century. For example, see analyses by Harding (1988) and Peters (1981) which draw on the theories of Foucault to explore the constructions of opiate addiction during this period.

problem which was the province of the medical profession, while the second saw addiction as a vice to be controlled penally.⁶ During the war, there was growing concern about the use of cocaine by soldiers. This prompted the introduction of the Defence of the Realm Regulation 40B which made it an offence for anyone to possess cocaine with the exception of members of the medical, pharmaceutical and veterinary professions. After the war, attempts to control, regulate and penalise drugs use continued. The Dangerous Drugs Acts of 1920 and 1923 were introduced which made possession of opiates and cocaine illegal and authorised the Home Office to regulate their sale, manufacture, and distribution.

The second phase of policy, from the work of the Rolleston committee and the publication of their report in 1926 to the early 1960s, was the period when the so-called 'British system' was perceived to be at its height. The Rolleston report defined addiction as a 'disease' requiring medical treatment and legitimised maintenance prescribing (Berridge, 1984). This period in British drugs policy history has received much attention from both British and American analysts. The 'British system' became regarded as the hallmark of success in drugs control around the world. In particular, American commentators perceived the approach advocated by Rolleston as more humane and effective compared with the penal and enforcement orientation adopted in US policy (see analyses by Schur, 1963; Lindesmith, 1965; Duster, 1970; Trebach, 1982). More detailed and developed analyses by British scholars have demonstrated that these accounts have been oversimplistic in their portrayals of the Rolleston report as the triumph of medicine over criminal justice. In particular, Berridge's analysis of the proceedings of the Rolleston Committee illustrates a process of accommodation between the Home Office and medical establishments, the growing partnership between doctors and the state in the control of addiction, and the control aspects of both penal and medical views (Berridge, 1984). Similarly, Carol Smart (1984a) draws on the theories of Foucault to illustrate the complexities of the overlapping systems of regulation and control surrounding drug addiction. She argues it is simplistic to suggest that the

⁶However, Smart (1984a: 36) offers an alternative view and argues that the medical profession also took a moral view on vice and was willing to call for repressive legislation to pursue medical aims such as compulsory treatment.

development of drugs policy is the outcome of the conflict between the Home Office and the medical profession as such a view can 'obscure the unity which underlies gradual shifts in policy' (Smart, 1984a: 36). Much of the analysis of this period has neglected the fact that there were low numbers of addicts at this time. As David Downes (1977:89) argues, the British system was 'little more than masterly inactivity in the face of what was an almost non-existent addiction problem'. This allowed for a general 'laissez faire medicalised approach' towards addiction to emerge during this period (Berridge, 1996b: 303). Although the balance between penal and medical forms of control has shifted over time, the systems established by the Rolleston committee have been symbolically important and have had an enormous impact on the development of subsequent drugs policy (Berridge, 1999).

The third phase in drugs policy development began with the second Brain Committee report⁷ in 1965 and continued through the 1970s. During the 1960s, there was growing public anxiety about increased drug misuse, the 'youth question' and the hippie movement, culminating in a series of 'moral panics' (see Young, 1971; Cohen, 1972). The growing drugs subculture and the over-prescribing by some doctors were important factors in the shift in policy (Berridge, 1999). The second Brain Committee put forward three linked proposals: restrictions on ordinary doctors prescribing heroin and cocaine to addicts; the establishment of drug treatment clinics staffed by psychiatrists; and the introduction of a system of statutory notification of drug addicts in treatment to the Home Office. However, Virginia Berridge (1999: 284) argues that the second Brain report did not mark a radical departure from the system established by the Rolleston committee, but a new 'realignment of the boundaries between law and medicine and a new emphasis on 'public health''. In her analysis of this period, Carol Smart (1985) has also shown the complex patterns of conflict and convergence over policy options both within the medical profession and between the Home Office and the medical profession.

⁷In 1958, the first Brain Committee commenced a policy review of the Rolleston arrangements and initially found that these were still appropriate. As a result of reports by the Home Office Drugs Inspectorate, the Committee was reconvened to consider issues around the prescribing habits of doctors (Berridge, 1999).

In practice, policy was determined locally by the individual doctors in the drug treatment clinics which effectively functioned as prescribing centres (Smart, 1985; Berridge, 1999). Such prescribing practices had led to a situation of 'institutionalised' drug use in which addicts were not striving for withdrawal and abstinence (Strang and Gossop, 1994). By the mid-1970s, doctors had become disillusioned with maintenance prescribing and its conflict with therapeutic ideals leading them to rethink their treatment strategies. Clinical trials comparing the effects of prescribing heroin versus oral methadone conducted by Hartnoll and Mitcheson (see Mitcheson and Hartnoll, 1978; Hartnoll et al, 1980) provided a further justification for a change in treatment philosophy. Although the research found that prescribing oral methadone was associated with a higher rate of abstinence, it also indicated that those who were not successful in becoming abstinent were more likely to be involved in crime to finance their continued drug use. In contrast, those prescribed heroin were less likely to engage in criminal activity. However, the use of oral methadone and the goal of abstinence was perceived by clinicians to be a more therapeutic and 'confrontational' response compared to maintenance and injectable heroin (Stimson and Oppenheimer, 1982).

The fourth phase of policy development began in the 1980s⁸ when drugs policy became shaped by a heroin epidemic. This was associated with a younger group of 'new heroin users' who tended to be concentrated in areas with high levels of unemployment and social deprivation (Pearson, 1987a). Stimson (1990a: 266-267) identifies several trends in drugs policy development in the 1980s: the decline of the clinic; the rise of the community, the discovery of the 'problem drug taker'; the shift from specialists to generalists; the role of the general practitioner; a new policy on control; and a new role for central government. The government's response to the heroin crisis was to draw up a strategy which proposed simultaneous action on five main fronts: reducing supplies from abroad; tightening controls on drugs produced and prescribed; improving policing; strengthening deterrence; and improving prevention, treatment and rehabilitation (Home Office, 1985). This marked an important shift in emphasis as enforcement and penal measures were given much more prominence. However, scholars such as Geoff Pearson

⁸This period will be covered in more detail in Chapters Three and Four.

(1991) and Virginia Berridge (1996a;1999) have argued that the advent of HIV/AIDS ensured that a harm reduction and public health perspective was revived and co-existed within this overall penal and enforcement framework. During the 1980s, a new layer of community-based drug treatment services funded through the Central Funding Initiative (CFI) were also created (MacGregor et al, 1991). Analyses by Berridge (1997) and MacGregor (1998a) have illustrated how the policy community around drugs broadened during the 1980s and 1990s to include new players such as social workers, probation officers, infectious disease specialists, public health professionals, GPs, and a reshaped voluntary sector. By the 1990s⁹ while the conflicts between penal and medical forms of control endured, there were also new emphases on prevention, involvement of the wider community and partnership approaches within British drugs policy. In 1995, the government introduced a new national drugs strategy, *Tackling Drugs Together*, which stresses these themes and signals a fifth phase in drugs policy development (MacGregor and Smith, 1998).

Several key themes, concepts and issues emerge from this cursory overview of drugs policy development and analyses. One important theme is the complex relationship between medical and penal forms of drugs control. This has been an enduring tension within policy development and an important focus of both historical and contemporary analyses (see Smart, 1984a; Berridge, 1999; Stimson and Oppenheimer, 1982; Pearson, 1991; Dorn and South, 1994). The conflicts between these forms of control manifest themselves in decisions regarding policy options and also at a structural or institutional level where there has been historical tension between the key government departments (ie. the Department of Health and the Home Office) over the control of policy. Although the prison system has not been a central feature of existing analyses, it has been mentioned in several accounts. It is within the prison environment that the tensions between penal and medical forms of control manifest themselves most acutely. For example, Berridge (1999: 274) notes that the prison doctors who gave evidence to the Rolleston Committee adopted a much harsher approach to dealing with drug addicts in prisons compared to their colleagues in the community by subjecting their patients to

⁹The fifth phase will be covered in greater detail in Chapters Five and Six.

abrupt withdrawal rather than maintenance prescribing. At the end of the 1980s, MacGregor (1989b:199) points to the lack of attention paid to the prison system in policy and service development arguing that 'this neglect is the real hidden scandal of the 1980s.' By the mid-1990s, the prison system was becoming much more of a focus in drugs policy discussions. For example, in relation to the 1995 prison drugs strategy, Berridge (1996b:304) highlights the growing convergence between medical and penal responses: 'the penal aspect of the health response as well as the health aspects of the penal approach are once more on the agenda'.

Various scholars have argued that the way in which the drug problem has been perceived, defined and redefined over time is an important influence on policy development (see for example Dorn and South, 1987; MacGregor, 1989a; 1998a; 1999a; Coomber, 1998; Jensen and Gerber, 1998; Berridge, 1999). As Susanne MacGregor (1999a:67) argues: 'social policy responses reflect the way a social problem is defined, which is in its turn affected by the character of social policy in that society'. Analyses have also shown that who the drug addict or user is becomes significant in how the problem is defined and understood (Berridge, 1984; 1999; Harding, 1988; Lart, 1998; South, 1999). In particular, race, gender and class are important factors influencing the construction of drugs 'problems' and the types of policy adopted. Equally important however are the data on the real extent and nature of the social phenomenon which include indicators such as the size of the drug problem, its social and physical location, and the characteristics of the drug users (MacGregor, 1999a).

The concepts of 'policy community' or 'policy network' have also been important features in analyses of the development of drugs, alcohol and AIDS policy (see Altenstetter, 1994; Berridge, 1996a; 1997; Thom, 1997; 1999; MacGregor, 1998a). For example, Virginia Berridge (1996a) explores the development of the AIDS policy community and illustrates how it evolved over time as the disease became normalised, professionalised and institutionalised. By the late 1980s, a 'two-tiered policy community had emerged with inner and outer policy circles' (Berridge, 1996a: 155). In a comparative analysis, Berridge (1997) points to the similarities between the drugs and AIDS policy communities in terms of the nature of the relationships between doctors and

the State and argues that medicine has remained central in both policy areas. Doctors moved from outside lobbying positions into more formal expert advisory positions while medical civil servants played important gatekeeping roles. Over time, there has been a downgrading of medical advice in relation to drugs as they have become the focus of a wider range of players with the rise of the non-medical voluntary sector (Berridge, 1997). In another analysis, MacGregor (1998a) points to the continued success of the drugs policy community in influencing the direction and implementation of policy during the 1980s and its ability to reach internal agreement at key moments.

A related theme to the policy network concept is the role of the committee or working group. Stimson and Lart (1994:335) argue that historically policy-making was achieved through committees of the great and the good such as the Rolleston and Brain Committees: 'there was no politicisation of drugs problems, indeed in true gentlemanly British fashion, politics were excluded from debate'. In the contemporary period, the Advisory Council on the Misuse of Drugs (ACMD)¹⁰ has been described as the 'single most influential body in British drugs policy and practice' (Ashton, 1994: 1). A key feature of the development of drugs policy is that it has often been 'achieved through the preparation of closet policy' (Strang and Gossop, 1994: 344). Although policy-making could be viewed as a privatised process, the roles of committees and experts have been nevertheless important. Their reports and recommendations may not become 'official' policy, but they do have an impact, particularly at the practical level in the development of services (Strang and Gossop, 1994). As MacGregor (1998a: 134) argues, the real power of policy networks lies in the detail of implementation and practice, rather than in the writing of grand policy statements.

The relationship between research and policy has been an important feature in analyses of policy development in the substance misuse areas (see Edwards et al (eds), 1993;

¹⁰ The ACMD consists of academic experts and professional practitioners in the area of drug misuse. The work of the ACMD is carried out by committees and working groups which publish reports on various aspects of the drugs problem. Under the Misuse of Drugs Act 1971, their terms of reference are as follows: 'to keep under review the situation in the United Kingdom with respect to drugs which are being or appear to them likely to be misused and of which the misuse is having or appears to them capable of having harmful effects sufficient to constitute a social problem' and to advise Ministers on measures to be taken' (quoted in HM Government, 1994: 22).

Berridge and Thom, 1996; Thom, 1997; Brownstein, 1998). In particular, Berridge and Thom (1996) use case studies of policy on drugs, alcohol and smoking to explore the relationship between research and policy. In relation to drugs, they focus on two pieces of research – the clinical trial of heroin and methadone prescribing in the 1970s (Mitcheson and Hartnoll, 1978; Hartnoll and Mitcheson, 1980) and the evaluation of syringe exchange schemes in the 1980s (Stimson et al, 1988). Berridge and Thom (1996) argue that the research on heroin and methadone prescribing did not determine policy, but provided justification and legitimation for policy changes which were already underway. In the case of the research on the syringe exchange schemes, Berridge and Thom (1996) illustrate how responsibility for the decision to implement syringe exchange schemes was deflected out of the political arena into the research arena. They conclude that the research-policy relationship is influenced by the policy community, the role of medical civil servants, the historical context and local traditions in particular policy areas.

The notions of ‘policy continuity’, ‘policy durability’ and ‘policy feedback’ are also important concepts in policy analyses (see Berridge, 1989; 1991; 1999; Pearson, 1991; MacGregor, 1998a; Stimson and Lart, 1994; Lart, 1996). Themes in contemporary drugs policy have powerful historical antecedents (Berridge, 1989). MacGregor (1998a:132) illustrates how ‘policy decisions taken previously, and the institutional arrangements which followed, laid down the parameters within which later choices would be made’. For example, Stimson and Lart (1994) argue that the discourses of harm minimisation, risk reduction and public health during the late 1980s were not so unusual and have a long history within past drugs policy. Similarly, Lart (1996) employs a Foucauldian framework to trace the genealogy of drugs policy and demonstrates how the response of syringe exchange and harm minimisation was possible in the 1980s. Moreover, Pearson (1991:169) concludes ‘there is a persistent thread of continuity through which the ‘British system’ retains the possibilities of a flexible and adaptable approach to drug problems’. Harm minimisation offers a point of continuity within British drugs policy.

The theme of policy transfers is also present in analyses of drugs policy. In the case of HIV/AIDS, Stimson (1994) and Berridge (1996a; 1999) have argued that the Scottish

experience, where a shortage of syringes was linked to facilitating the spread of HIV, and the work of the McClelland Committee, which advocated a harm minimisation policy, gradually led to the adoption of a similar policy with the development of syringe exchange schemes in England. A common assertion is that British drugs policy has been heavily influenced by the United States. However, as Mott and Bean (1998) argue there is little evidence to support this claim. Similarly, MacGregor (1998a) suggests that in other areas of public policy, such as welfare, criminal justice, and race relations, Britain has borrowed policy ideas from the United States, but in the area of drugs, there has been much confidence in British ideas and knowledge. This is related to the presence of the medical profession and the body of knowledge in the voluntary sector. However, this is not the case where drugs policy has overlapped with criminal justice policy. There is evidence of policy transfers from the United States in these areas as closer links are developed between criminal justice and treatment. Within the British criminal justice system, initiatives such as drugs testing, compulsory treatment, and drug courts are becoming increasingly important in contemporary policy. Similarly, South (1998: 95) shows how the UK has aligned itself to US drugs control and enforcement policy on the international stage and illustrates the pressures of the 'overarching hegemonic 'internationalization' of US law enforcement'.

The development of drugs policy must be understood as part of the broader trends within wider policy and institutional frameworks (Stimson and Lart, 1994; MacGregor, 1998b; Dorn and Lee, 1999). For example, Dorn and Lee (1999) analyse the impact of managerialist frameworks upon drugs control policy and argue this has enabled enforcement agencies to reconstruct their aims and objectives so that they are more 'manageable' and 'achievable'. Similarly, the notion of 'partnership' has been applied in British drugs policy as well as other policy areas such as crime prevention and community safety, urban regeneration, health and education. Other policy subsystems and the 'community' have therefore been drawn into the management of the contemporary drug problem as the concepts of 'partnership', 'multi-agency working', and 'prevention' become important themes. A distinctive feature of the new partnership structures is the closer alliance between the criminal justice system and other agencies. MacGregor (1998a:135) argues that partnerships and the moves towards multi-agency

and multi-disciplinary approaches represent a standard form of new regulation which is now evident in all areas of social policy.

In conclusion, it is clear that the existing literature on drugs policy development has failed to provide systematic analyses of the dynamics of the policy process itself. Stimson (1990a) identified several key areas for future drugs policy research which included studies exploring the politicisation of policy and the locus of policy-making, the nature of the policy process, the individuals, agencies and institutions involved in policy-making, and the role of research. Although few scholars have employed an approach derived from the policy studies literature in their analyses, this would offer a fruitful method to explore these dimensions of policy-making.

Analyses of penal policy

Similar to drugs policy analyses, there is a paucity of research which specifically explores the nature and dynamics of the penal policy process. A rare account is that offered by Adler and Longhurst (1992; 1994) who examine the day-to-day administrative decision-making in the Scottish prison system focusing on the discourses of the various players involved in the policy process. Similarly, if one moves into the wider realm of criminal justice policy-making, the work of Paul Rock offers important insights from a symbolic interactionist perspective into policy-making around victim's issues in the Ministry of the Solicitor General of Canada and in the British Home Office (see Rock 1986; 1990; 1994; 1995). There has also been an emphasis in criminological work on the political dimensions of policy (see for example Brake and Hale, 1989;1992; Downes (ed) 1992; Reiner and Cross, 1991; Downes and Morgan, 1997; Nash and Savage, 1994) With the exception of work by James and Raine (1998) and Raine and Willson (1993;1997), there are few analyses of penal and criminal justice policy from a public administration or political science perspective. However, several analyses from a variety of disciplinary and theoretical perspectives do include and emphasise aspects of the policy-making process. Parallel themes, concepts and issues to those highlighted above in drugs policy analyses can also be located in analyses of penal policy. For example, the tensions

between medical and penal forms of control in drugs policy are mirrored within penal policy development.

The competing paradigms or discourses of 'rehabilitation' and 'welfare' focusing on the individual offender versus 'punishment' and 'justice' focusing on the crime committed are important components of much analysis of penal policy. The development of prisons as locations for the 'reform' of individuals into productive, law-abiding citizens in the nineteenth century has been well documented (see Foucault, 1977; Ignatieff, 1978; Garland, 1985). By the late nineteenth century, reform as the primary goal of penality was replaced with rehabilitation.¹¹ This shift was linked to the development of the welfare state, the introduction of 'Fordism' or systems of mass production, and the development of new disciplines such as psychology, psychiatry and criminology (Matthews, 1999). In an analysis of this period, David Garland (1985) has traced the development of the 'penal-welfare' strategy and illustrates how its goal was not to reform offenders or prevent crime, but to administer and manage criminals and criminality using the new forms of knowledge. From the end of the Second World War to the early 1970s, the rehabilitative ideal was at its height. The focus of treatment, training and rehabilitation was aimed at attempting to resocialise and reintegrate the individual back into the community. In Britain, this commitment to rehabilitation was enshrined in the Prison Rules in 1964 which stated: 'the purpose of the training and treatment of convicted prisoners shall be to encourage and assist them to lead a good and useful life' (Prison Rules, 1964, Rule 1).

By the late 1960s, the penal-welfare strategy began to unravel as rehabilitation came under attack from both the left who saw it as unjust and oppressive (Cohen, 1979; 1985; Austin and Krisberg, 1981) and the right who considered it to be a soft option. Thus the optimism, confidence and consensus surrounding the 'rehabilitative ideal' began to collapse and was reinforced by research evidence questioning the efficacy of

¹¹The concepts of reform and rehabilitation are often used interchangeably. Barbara Hudson (1987) argues that they should be separated for historical and analytical reasons. Her preference is to use 'reform' to refer to the development of regimes in the nineteenth century which were aimed at changing individuals through education and contemplative techniques and to use 'rehabilitation' to refer to the more individualised treatment programmes of the twentieth century.

rehabilitation and treatment in reducing recidivism (see Martinson, 1974; Lipton et al, 1975; Brody, 1976). As a result the 'nothing works' doctrine began to emerge and provided further justification for a change in direction. Since the collapse of rehabilitation, penal administrators have tried unsuccessfully to develop a new philosophy or rationale for punishment (Garland, 1990). Attempts at establishing a new penal policy framework include the justice model of sentencing (von Hirsch, 1985), 'humane containment' (King and Morgan, 1980), the non-treatment paradigm (Bottoms and McWilliams, 1979), selective incapacitation (Greenwood and Abrahamse, 1982), the reaffirmation of rehabilitation (Cullen and Gilbert, 1982), and abolitionist approaches (Christie, 1982).

By the 1980s, the 'justice model' had moved to the forefront of criminal justice policy, particularly in the area of sentencing. This was evident in the provisions of the 1991 Criminal Justice Act. Proponents of this approach argue that punishment should be proportionate to the crime, rather than the individual's response to punishment (von Hirsch, 1985; 1990). In Britain, a version of the 'justice model' was applied to the prison environment by King and Morgan (1980) in their evidence to the May Committee. They argued that a policy of 'humane containment' should be adopted which would be underpinned by three key principles: minimum use of custody; minimum use of security; and the 'normalisation' of the prison which meant that 'the same general standards which govern the life of offenders in the community should be held to apply to offenders in prison' (King and Morgan, 1980: 37).

By the mid-1990s, a more punitive version of 'just deserts' had emerged which abandoned the central principles of the 1991 Criminal Justice Act. Based on ideas generated by American academics (Wilson, 1975; Murray, 1990; 1994; 1997) and American policies such as 'three strikes and you're out', arguments about the efficacy of prisons in terms of incapacitation and deterrence were being articulated in the UK, particularly by the Home Secretary, Michael Howard who proclaimed that 'prison works' in 1993. This policy discourse amplified the tension between the welfare and justice paradigms. As James and Raine (1998: 86) argue, 'rather than a tension to be managed, the two were set in opposition to one another'.

Contemporary analyses have illuminated the tensions between the competing discourses within penal policy and the problems of balancing and containing such contradictory discourses. The work of Foucault has had a profound impact upon analyses of penalty illustrating the punitiveness and expansion of penal policies (see Donzelot, 1980; Garland, 1985; 1990; Cohen, 1985; Sim, 1990; Adler and Longhurst, 1992; 1994). Drawing on the theories of Foucault and Mannheim, Adler and Longhurst (1994) explore policy-making in the Scottish prison system by focusing on the discourses of the different policy actors and the tensions between them. A distinction is drawn between 'ends' discourses which are concerned with rehabilitation, normalisation, and control and 'means' discourses which are concerned with bureaucracy, professionalism and legality. The 'ends' discourses focus on the individual prisoner. The aim of the 'rehabilitation' discourse is to reintegrate and socialise the 'deviant' individual into society, the 'normalisation' discourse aims to ensure that the 'normal' individual does not become 'worse' during imprisonment, and the 'control' discourse emphasises the control and smooth operation of the prison system targeting the 'disruptive' individual. In contrast, the 'means' discourses focus on the various policy actors involved in decision-making. The 'bureaucratic' discourse is associated with the civil servants, focuses on the prison system as a whole, and derives legitimacy from its claims to impartiality and fairness; the 'professional' discourse is associated with prison governors, focuses on individual prisons, and derives its legitimacy from grounded experience and intimate knowledge; and the 'legal' discourse is associated with the courts and legal system, focuses on individual prisoners and derives its legitimacy from the rule of law. Adler and Longhurst (1992:94) argue that the task of policy-makers is to try to produce an 'optimum balance between the competing claims of [these] intrinsically persuasive forms of discourse'.

The contradiction and convergence between care and control therefore manifest themselves in the values and ideologies of penal practitioners and professionals (Garland, 1990; Adler and Longhurst, 1994; Rutherford, 1993). Andrew Rutherford (1993: 3) identifies three sets of values and beliefs which shape the work of criminal justice practitioners. These include the 'punishment credo' which involves the punitive degradation of offenders, the 'efficiency credo' which emphasises management, pragmatism, efficiency and expediency and the 'caring credo' which centres upon liberal

and humanitarian values. Using the narratives of a mix of criminal justice practitioners who adhere to the 'caring credo', Rutherford (1993) explores the development of this ideology and illustrates how these practitioners attempt to hold on to their core values while adapting their practical expression to new understandings and changing circumstances. The challenge for those who adhere to the notion of reform and the caring credo is to avoid 'co-option, marginalisation or rejection by the organisation' (Rutherford, 1993: 83). For David Garland (1990) however, the way in which penal professionals present themselves is a guise. The various groupings – governors, prison officers, social workers, probation officers, medical officers, psychiatrists and drug workers – have their own claims to specialised expertise and tend to present themselves positively as 'reformers' or 'carers' rather than as the 'instruments of punishment' or 'vehicles of punitive reaction' (Garland 1990: 183).

In other analyses of the competing aims of imprisonment, the notion of 'balance' is also a central feature. For example, King and McDermott (1992) explore the complex relationship between security, control and humane containment in the prison system in England and Wales¹². Their analysis points to the inhumanity and deterioration of the containment offered by the prison system during the 1980s. Measures taken to increase security and the greater use of restrictions to improve control contributed both directly and indirectly to the deterioration of regimes (King and McDermott, 1992). The Woolf Inquiry into the riots at Strangeways and other prisons in April 1990 was also concerned with the concept of 'balance'. Lord Justice Woolf identified three requirements which must be met and balanced if the prison system was to remain stable: security, control and justice. Security was defined as the need to prevent prisoners from escaping, control as the obligation to prevent prisoners from causing a disturbance and justice as the obligation to treat prisoners with humanity and fairness (Woolf and Tumin, 1991:17, para1.149).

¹² King and McDermott (1992: 97) define security as 'matters that relate directly to keeping prisoners physically in custody'; control as 'matters that relate to the maintenance or restoration of social order within prisons when it is perceived to have been put under threat'; and humane containment as 'aspirations to provide decent conditions for prisoners in terms of physical facilities, regime activities, contact with families and so on'.

The growing preoccupation with security, punishment and control issues has caused various commentators to call for the reaffirmation of rehabilitation within penal policy (see for example, Cullen and Gilbert, 1982; Carlen, 1989; Rotman, 1990; Matthews, 1992; Hudson, 1993; Raynor, 1997). In the post-‘nothing works’ era, several research reviews and programme evaluations have indicated that some programme components can produce positive effects (see Ross and Fabiano, 1985; 1988; Raynor, 1988; Andrews et al, 1990; Petersilia, 1990; Raynor et al, 1994; McGuire, 1995). The ‘new rehabilitationists’ argue that only rehabilitation as a penal aim can prevent future offending. The new models of rehabilitation are compatible with the contemporary penal discourses of proportionality, rights and desert-based sentencing (Hudson, 1993). For example, Raynor (1997:259) explores the perceived incompatibilities between the ideas and policies associated with rehabilitation and those associated with just deserts and concludes that rehabilitation is compatible within a model of organic justice which is socially contextualised and ‘aims at compatibility with social justices and communal solidarity’. The new rehabilitationists argue for much more than just minimum standards and humane containment in prisons. They propose that prison sentences should include programmes and initiatives designed to prevent future crimes and to punish crimes already committed (Hudson, 1993). For example, Roger Matthews (1992: 80) argues that rehabilitation should be reaffirmed provided that it is conceived of in broader and more social terms; a wider range of measures are used to assess its effectiveness; and that constructive interventions are developed for the short-term.

At the same time, some observers of contemporary penal policy argue that a ‘new penology’ has emerged which involves a shift away from the individual towards the aggregate (Feeley and Simon, 1992; 1994). Its goals are managerial rather than transformative. The new penology is not concerned with rehabilitation, treatment, interventions or even punishment for the individual offender, rather it emphasises managerial processes and ‘techniques to identify, classify and manage groupings sorted by dangerousness’ (Feeley and Simon, 1992: 452). Interestingly, Feeley and Simon (1992) argue that drug misuse has become a major feature of the contemporary penal landscape and the new penology. Drug misuse is treated as a risk indicator for re-offending and employed as a criterion to classify offenders. The new initiatives around

drugs are often represented in the language of the old penology with its focus on individuals, reform and rehabilitation; however, in practice greater emphasis is placed upon drug testing than drug treatment. In effect, testing fills the gap left by the decline of other treatments, interventions and programmes. As Feeley and Simon (1992:462) argue, 'by marking the distribution of risk within the offender population under surveillance, testing makes possible greater coordination of scarce penal resources'.

In contrast to drugs policy and other areas of public policy, the concepts of 'policy communities' or 'policy networks' have not been employed explicitly in analyses of penal or criminal justice policy¹³. Various scholars have explored the role and power of certain groups in the policy process including civil servants (see Rock, 1986; 1990; 1994; 1995; Downes and Morgan, 1997; Rutherford, 1996; Adler and Longhurst, 1994) and interest and pressure groups (see Ryan, 1978; 1983; Stolz, 1985; Ryan and Ward, 1992; Carlen and Tchaikovsky, 1996; Downes and Morgan, 1997; Stern, 1994; 1998; Roberts, 1998). For example, Adler and Longhurst (1994) identify five groups of actors in the inner core of the Scottish prison system: civil servants located in Prison Service headquarters; prison governors; prison officers; prison professionals including chaplains, social workers, education officers, medical officers, psychologists, and psychiatrists; and the prisoners themselves. In relation to administrative decision-making, Adler and Longhurst (1994) argue that civil servants and prison governors are the most important players. In the wider realm of criminal justice policy, contrary to the popular stereotype of passive bureaucrats, analyses have portrayed civil servants as proactive and innovative, particularly in the areas of programme development and in the preparation of the 1991 Criminal Justice Act (see Rock, 1994; Downes and Morgan, 1997).

Several commentators have stressed the importance of pressure groups in the policy process (see Ryan, 1978; 1983; Ryan and Ward, 1992; Stern, 1994; 1998; Carlen and Tchaikovsky, 1996; Downes and Morgan, 1997). During the 1980s, there were increasing links between the Home Office and pressure and practitioner groups. The

¹³ An important exception is Adam Crawford's work on the local governance of crime. Crawford (1997) employs the policy network concept to analyse local relations within community partnerships in the area of crime prevention.

Thatcher government preferred to use ad hoc official inquiries rather than the traditional Royal Commissions and standing advisory bodies. Downes and Morgan (1997:115) argue that this decline in the use of 'officially organised advice' led to the professionalisation of pressure groups. However, the 1990s were characterised by lack of consultation and open debate between government and outside groups. Pressure groups, practitioners, professionals, and academics have not had the same opportunities to influence the policy process (Faulkner, 1996; Rock, 1995; Downes and Morgan, 1997). Paul Rock (1995: 2) points to changes in contemporary criminal justice policy-making from standardised processes of consultation towards more fragmentary, loose procedures:

The newest modes of policy-making are themselves the fruits of a new politics of populism, moralism, and the market....a number of Home Office ministers appear recently to have been impelled by a strong sense of the political, by personal volition, a doughty common sense, and appeals to what are thought to be popular sentiment. They have consulted and conferred less often with the experts, distrusting the professionals, the criminologists, officials, and practitioners, who used to define much of the character of crime and criminal justice policy.

However, scholars such as Matthews (1992) and Rutherford (1993) emphasise the power and resistance of criminal justice practitioners and argue that in order to implement policy changes and reforms, there is a need for the tacit agreement of the agencies concerned. Even if agencies have formally accepted and complied with particular policies, informal practices may continue to be sustained and endorsed. Penal reform can often emanate from below, thus making it difficult for policy-makers to impose unpopular or unwanted policies (Matthews, 1992). Similarly, Garland (1990) stresses the importance of examining the daily routines and institutional practice, rather than concentrating solely on the grand, official policy statements.

The concepts of 'policy continuity', 'policy durability' and 'policy feedback' are also relevant to the development of penal and criminal justice policy. Prior to the 1990s, several commentators recall a sense of continuity and pragmatism in policy development (see Rock, 1995; Garland, 1996; Faulkner, 1996; James and Raine, 1998). Policy

proposals contained a history and links with existing policies and programmes. However, the penal populism and policies advocated by Michael Howard in 1993 indicated a very sudden and radical change in penal policy leading to a 'remarkably volatile and ambivalent pattern of policy development' (Garland, 1996: 449). Since the election of the Labour government in 1997, a sense of continuity has been restored. Commentators, including Morgan (1999) and Brownlee (1998), note the continuities and similarities between Conservative and Labour penal policy.

The relationship between research and policy has not been the focus of many analyses of penal policy. In relation to criminal justice policy-making, Rock (1995: 7-8) argues that although policy-makers would like to assume that they are supported by experts and evidence, it is often the case that politicians and officials view research as a nuisance or political hazard. As in drugs policy, research has played a role in the penal policy process often to justify and support policy proposals already in train. As discussed above, an important example is the research associated with the decline of the rehabilitative ideal in the 1970s which indicated that 'nothing works' in terms of treatment and rehabilitation in prisons (see Martinson, 1974; Lipton et al, 1975; Brody, 1976). This provided a further justification for a shift in policy towards the justice model. There is now a growing body of evidence and research which questions the notion that 'nothing works' and suggests that some programmes and initiatives in prison can be effective (see Ross and Fabiano, 1988; Raynor, 1988; McGuire, 1995). Similarly, American research and evidence provided important justifications for incapacitative policies advocated by Michael Howard in 1993 (see Murray, 1990; 1994; 1997).

Although there has been little analysis and research, the role of 'policy transfers' are significant in penal policy development. The shifts in penal policy such as the decline of rehabilitation, the move towards the justice model, the growth of privatisation, and the subsequent shift towards incapacitation and mandatory sentencing all have their antecedents in North American policies. Similarly, the recent arguments that 'something works' and the rehabilitation programmes stressing cognitive reasoning also have their roots in North America (Ross and Fabiano, 1985; 1988). In his analysis of the Programme Development at the Home Office, Paul Rock (1994) notes how civil servants

who had previously held posts in North America began to channel North American models, policies and practices into the Home Office. These 'transfers' have also taken the form of penal institutions themselves! In 1997, a prison ship no longer used by the New York prison authorities was ferried over from the United States and docked in Portland, Dorset to be used by the Prison Service.

Although more insulated compared to other policy areas, penal policy has been affected by developments in other policy subsystems. Barbara Hudson's analysis of the inter-relationship between penal and social policy illustrates the close relationship between the two domains (Hudson, 1993). She effectively argues that the same ideological and material forces affect the development of both sets of policies and that they deal with the same 'client' groups - the poor, the disturbed and the addicted. In his analysis of criminal justice policy-making, Paul Rock (1995) also argues that a key imperative of policy proposals is that they must interface with the wider agenda and context. In particular, during the 1980s and 1990s, the institutions of criminal justice became increasingly preoccupied and influenced by the wave of managerialism sweeping through the public sector which emphasised cost-effectiveness, efficiency, value for money, measurement of performance, private sector styles of management and privatisation. Several commentators have traced the development of managerialism in relation to criminal justice policy (see Raine and Willson, 1993; 1997; McLaughlin and Muncie, 1994; James and Raine, 1998) and the debates around privatisation and the mixed economy of criminal justice and penal provision (see Matthews (ed), 1989; Ryan and Ward, 1989). A common theme which emerges from the literature is the notion that managerialism is not concerned with the overall purpose of the criminal justice system or imprisonment, but with the management of crime, punishment and criminals (Feeley and Simon, 1992; Garland, 1996; Raine and Willson, 1998). The principles of partnership, crime prevention and involving the community in criminal justice are also prominent themes in policy. As Garland (1996) cogently argues, the managerialist trends intersect neatly with the partnership principle, multi-agency approaches and the rise of the community where the state seeks to activate action on the part of non-state agencies and organisations to take responsibility for controlling crime.

In conclusion, this brief review of the literature on penal policy has highlighted important themes. It has also demonstrated the lack of research on the nature and dynamics of the penal policy process which could be explored most successfully using literature from the policy sciences. Based on the existing literature on drugs and penal policy, it has been possible to choose two central themes which could be applied to my analysis of the contemporary development of prison drugs policy. The first is the influence of policy networks in the process of policy development and the second is the tension, contradiction and convergence between treatment and punishment. I am using the term 'treatment' to cover a range of activities which involve 'caring' for individual drugs misusing prisoners such as detoxification, maintenance prescribing, harm reduction measures, drug-free wings, drugs counselling, throughcare and aftercare services, and practical help and advice. The term 'punishment' refers to those activities which involve 'punishing' or 'controlling' drugs misusing prisoners such as mandatory drug testing and the associated sanctions, and security measures including cell and body searches, CCTVs, use of sniffer dogs, intelligence gathering, and targeting visitors. However, it is important to note that caring measures and controlling measures often converge. Control and punishment can also be viewed as methods of 'caring' for prisoners. For example, creating a drug-free prison environment can be viewed as caring for prisoners. Similarly, care and treatment measures can be viewed as methods of 'controlling' and 'punishing' prisoners. Examples include the practices of abrupt withdrawal, coerced treatment, and withdrawing privileges for positive drug tests.

Since the early 1990s, drug issues in prison have become increasingly important in drugs and penal policy debates leading to the development of very explicit policies in 1995. Since 1980, prison drugs policy can be divided into four main phases of development: 1980-1986; 1986-1993; 1993-1997; and 1997-ongoing. A central contention of this thesis is that this policy development has hinged upon the complex patterns of conflict, contradiction and convergence between treatment and punishment. Throughout the phases, particular 'policy networks' have evolved around drug issues within the prison system, becoming more complex in their structure and operation over time. It will be argued that these networks have played key roles in containing, balancing and managing the contradiction between treatment and punishment and that their activities have been

influenced by a) how the drug problem in prison has been framed and defined; b) research, evidence and knowledge; and c) wider contextual features. This research therefore aims to address the following questions which are interlinked:

How influential have the policy networks around drug issues in prison been in the development of policy? When have they been most influential and why?

How have these networks attempted to contain the contradiction between treatment and punishment in policy development?

How has this 'containment' been shaped by changes in the way in which the drug problem has been framed and defined, new research, evidence and forms of knowledge, and the impact of wider political, policy, social and institutional contexts?

The next sections will outline the approach which will be employed to analyse these research questions and explore the key concepts and theories which helped to direct and focus them.

Policy and policy analysis

Key dimensions of policy

There is a lack of consensus as to what constitutes 'policy' and how the term should be defined. Various scholars have put forward different definitions (see Heclo, 1972; Easton, 1965; Anderson, 1975; Hogwood and Gunn, 1984; Levin, 1997). Hill and Bramley (1986) suggest that policy should not be treated as a self-evident, concrete or constant phenomenon. They argue that any attempt to define policy will be artificial in that what we are trying to define is contested. Similarly, Gordon et al (1993: 8) suggest it is misleading to view policy analysis as the study of 'identifiable things called policies which are produced, or crystallise, at a particular stage in the decision process'. Thus, policy should be conceived of in more fluid and dynamic terms. It is helpful nevertheless to place at least some loose parameters around the term and outline some of its key dimensions. Jenkins (1978:15) offers one of the most useful working definitions of public

policy:

A set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specified situation where these decisions should, in principle, be within the power of these actors to achieve.

As outlined by Jenkins (1978) and elaborated on by Hill and Bramley (1986), this definition has a number of strengths encapsulating several key dimensions of policy. These features of the definition make it particularly suitable for the analysis of prison drugs policy. Firstly, it emphasises that policy is more than a single decision, but involves a series or pattern of decisions extending over time. So, rather than focusing on one particular shift in prison drugs policy, I have adopted a more longitudinal approach by exploring a series of policy decisions extending over a period of nearly two decades. Secondly, the term 'political actors' could be expanded to include officials, politicians and other policy influencers. This is important in the analysis of prison drugs policy because several groups have been involved in decision-making. Thirdly, the definition stresses that both means and ends are involved in policy. In prisons drugs policy, the means by which the policy was pursued were, arguably, of equal significance to the desired end result of the policy. Fourthly, the definition emphasises that policies are contingent in that they refer to or depend on a specified situation. Prison drugs policy has been shaped by a wider political, social, institutional and policy context. Fifthly, policy is restricted to that which can be achieved or those 'matters over which the state has authority, and to actions/results which are practically feasible' (Hill and Bramley, 1986: 3). Decisions taken in relation to the development of prison drugs policy have been restricted to what can be feasibly or practically achieved within the authority of the state.

Another important feature of the definition is that it also allows for the possibility for inaction or the decision not to move (Jenkins, 1978). Policies can therefore refer to what is not being done (Hecl, 1972). The absence of policy is also defined as a 'policy'. In a similar vein, policies can serve symbolic purposes. They are often created only to give the impression that action is being taken by government in order to maintain political support, but leaving the particular problem untackled (see Edelman, 1964; 1971; 1988). In many cases there can be barriers to some policy issues or problems becoming public.

Therefore, political activity may be mainly concerned with maintaining the status quo and resisting challenges to the existing circumstances (Ham and Hill, 1993). As we will see in later chapters, this was the case with the drug issue in prisons for many years. There was no official admission that drugs were a 'problem' in the penal setting which meant that the issue was not being addressed by formal policy. A public acknowledgement that drugs were problematic would have been a tacit admission of the failure or non-existence of policy. There is also a need to look at the unintended consequences of policy or outcomes which may or may not have been foreseen. It can be argued that the development of prison drugs policy has led to several unintended consequences which will be explored in subsequent chapters.

Policy analysis

Wildavsky (1979:15) emphasises the 'art' and 'craft' of policy analysis which involves imagination, thought and creativity. A range of activities are involved in the process of analysis. Gordon et al (1993)¹⁴ have created a typology distinguishing between two main types of policy analysis: analysis *for* policy and analysis *of* policy. Analysis *of* policy is essentially an academic activity which is concerned with advancing knowledge and understanding of the policy process, whereas analysis *for* policy is primarily an applied activity concerned with the solution to social problems and generating knowledge for the policy process (Ham and Hill, 1993). Within this dichotomy, a continuum of activities can be identified including policy advocacy, information for policy, policy monitoring and evaluation, analysis of policy determination and analysis of policy content (Gordon et al, 1993). Similarly, Hogwood and Gunn (1984) identify several approaches to the analysis of policy including studies of policy content, policy process, policy outputs, evaluation studies, information for policy-making, process advocacy, and policy advocacy. Within Gordon et al's typology, my study of prison drugs policy best fits into the category of analysis *of* policy and that of *policy determination* which emphasise 'the inputs and

¹⁴This reference originally appeared in 1977 as Gordon, I., Lewis, J., and Young, K. (1977) "Perspectives on policy analysis", *Public Administration Bulletin*, 25, 26-30.

transformational processes operating on the construction of public policy' (Gordon et al, 1993: 6). Within Hogwood and Gunn's classification, my analysis best fits into their category of studies of the *policy process* which are concerned with exploring the various influences on the development of a policy issue and how this development unfolds over time. However, it can also be classified as a study of *policy content* in that I seek to describe and explain the origins, changes and developments within prison drugs policy.

It is difficult to locate policy analysis within existing disciplinary categories. It is a field which is composed of various models, theories and disciplines. Analysts of public policy often find it useful to adopt an open and multi-disciplinary approach to their subject which draws on several different disciplines (see Lasswell, 1951; Wildavsky, 1979; Hogwood and Gunn, 1984; Ham and Hill, 1993; Parsons, 1995; John, 1998). For example, Wildavsky (1979: 15) argues that policy analysis should be considered as an 'applied sub-field whose content cannot be determined by disciplinary boundaries but by whatever appears appropriate to the circumstances of the time and nature of the problem'. Similarly, Ham and Hill (1993: 11) argue that policy analysis must be a multi-disciplinary pursuit and its purpose is 'to draw on ideas from a range of disciplines in order to interpret the causes and consequences of government action, in particular by focusing on the processes of policy formulation'. Hogwood and Gunn (1984: 30) also stress that policy analysis must develop 'an integrated, or interdisciplinary approach, which will combine in a synergistic manner elements from many disciplines'. It became clear during the course of my research that an analysis of drugs policy development in prisons failed to fit neatly into any one disciplinary category. The 'problem' of drug misuse in prison has several dimensions. It can be viewed as a drug issue, penal issue, legal issue, public health issue, medical issue, community issue, crime issue, political issue, economic issue and so on. It follows that the subject of prison drugs policy can be viewed through a variety of different disciplinary lenses including criminology, sociology, law, political science, public administration, history, medicine, and so on. In my analysis, I have therefore found it useful to adopt a multi-disciplinary approach which draws on the ideas, theories, concepts and research from a variety of social science disciplines including social policy, criminology, sociology, political science and public administration. The literature from the area of 'policy studies' or 'policy sciences'

provides a useful overarching theoretical and conceptual framework for this study.

The attractions and limitations of the 'stages heuristic'

Traditional models of the policy process are based on the notion that policy proceeds through a series of discrete stages (see Lasswell, 1956; Simon, 1947; Easton, 1965; Jones, 1970; Anderson, 1975; Hogwood and Gunn, 1984). Such models attempt to simplify policy-making and impose some form of conceptual order and clarity upon a process which is complex and can appear chaotic (John, 1998). Sabatier (1991) refers to this dominant paradigm of the policy process as the 'stages heuristic'. Within stages models, a rational, linear account of policy-making is offered in which the political system processes inputs and creates outputs. A particular policy cycle involves the recognition and definition of a problem, the identification of alternative responses, evaluation of options, selection of policy options, implementation, and evaluation (Parsons, 1995:77).

Stages models have been widely criticised, mainly for their inaccurate and artificial portrayal of the policy process (see Stone, 1989; Sabatier, 1991; Smith and May, 1993; Lindblom and Woodhouse, 1993; Sabatier and Jenkins-Smith (eds), 1993). They tend to mystify the policy process and fail to capture the reality, complexity and messiness of policy-making. Such models overstate the rationality of policy-making by suggesting that the policy process can be sliced up into separate analytical pieces. Policy is a continuous process and neat divisions do not exist between the different types of activities (John, 1998). As Lindblom and Woodhouse (1993:11) argue, 'deliberate, orderly steps...are not an accurate portrayal of how the policy process actually works. Policy-making is, instead, a complex inter-active process without beginning or end'. Sabatier and Jenkins-Smith (1993:1-4) outline five main limitations of the stages heuristic. Firstly, it fails to provide an explanation of how policy moves from one stage to the next; secondly, it cannot be tested empirically; thirdly, it is essentially a 'top-down' approach and does not consider 'street level' and other actors; fourthly, it does not consider the interaction of the multiple levels of government and other policy cycles; and

finally, it does not provide an integrated approach to the analysis of the policy process and the role of research and evidence.

Despite the criticisms and research which has questioned the assumptions of the stages policy cycle model, it has survived and persisted. Gordon et al (1993:8) postulate that the main reason for its continued existence must be in 'its status as a normative model and as a 'dignified' myth which is often shared by the policy-makers themselves'. The stages model can be useful as a learning or heuristic device which enables us to explore policy (Sabatier, 1991). In particular, it provides us with a rational structure to explore the complexity and multiplicity of the policy-making. Researchers often use it to impose order on the research process and it is here where its value lies. Several scholars have presented their analyses of policy development in a chronological framework which distinguish between various phases or cycles (see for example Ryan, 1983; Sim, 1990; Berridge, 1996a; Thom, 1997). In my analysis of prison drugs policy, the stages model was used to impose order upon the research process and to provide a framework for the presentation of this analysis.

Sabatier (1988; 1991) argues that longer term studies of the policy process covering a time perspective of at least a decade are needed for three main reasons. Firstly, this usually allows for policy to complete at least one formulation/implementation/reformulation cycle so that the success or failure of a policy can be assessed. Secondly, the 'enlightenment function' of research stresses that the cumulative effect of research findings impacts upon the policy process gradually (Weiss, 1977a), thus requiring a longer time period to assess its influence. Thirdly, in order to understand the significance of particular innovations in policy, policy-oriented learning, and the importance of changing socio-economic factors, policy analysis should be conducted over longer time periods. In order to assess the influence of various forces influencing the development of prison drugs policy, this research has therefore adopted a time perspective of approximately eighteen years from 1980 to 1998 which divides into four overlapping phases. This time period allows for an analysis of how policy has changed over the years in light of shifts in definitions and discourses around the problem of drugs in prison, the impact of evidence and research, shifts in related policy areas, and the

changing political, social and institutional contexts.

Towards a framework for analysing prison drugs policy: key concepts and theories

What is missing from the stages models is a theory or framework which explains why policy-makers adopt policies at particular times and places (Sabatier, 1991). Research on policy requires theories which help us to make sense of the policy process as a whole.

There are five main theoretical frameworks or approaches which can explain how policy is formulated and implemented. These include institutional, group and network, socio-economic, rational choice, and idea-based approaches. They have developed in reaction to each other and in response to the limitations of earlier analyses and theories (John, 1998). In this research, I have drawn most heavily on the policy network approach and 'new institutionalism' to provide the theoretical basis for the study. The next sections will outline the main features which will underpin the analysis which follows in Chapters Three, Four, Five and Six. A number of themes and concepts will be highlighted: the role of the policy network and the institutional context of policy development; the framing of the drug issue in prison; the relationship between research and policy; and the impact of shifts in wider contexts and related policy subsystems.

Policy networks

Analysing policy networks has become one of the dominant approaches to studying policy-making in the UK, Europe and North America (Dowding, 1995; Blom-Hansen, 1997). Various case studies have demonstrated the relevance and utility of the 'policy network' concept in describing the policy process in different sectors (see Heclo, 1974; Heclo and Wildavsky, 1981; Rhodes, 1986, 1988; Marsh and Rhodes (eds), 1992; Wilks and Wright (eds), 1987; Smith, 1993; Berridge, 1996a; 1997; Thom, 1999). Policy network approaches emphasise the interaction and patterns of association between various actors in particular policy areas. The type of relationships that form between civil servants, politicians, group representatives and others are seen to shape policy

outcomes and explain policy change. Rhodes and Marsh (1992a) characterise policy networks as meso level concepts which provide the link between the micro level of analysis dealing with the role of interests and the macro level of analysis dealing with the distribution of power within society. Policy networks both influence the policy process and reflect the relative status and power of the various interests in particular areas of policy (Rhodes and Marsh, 1992a).

The concept of the 'policy network' is one of the most contested terms in political science. Various scholars have conceptualised networks in different ways (see Richardson and Jordan, 1979; Rhodes, 1986; Wilks and Wright, 1987; Sabatier, 1988; Hajer, 1993; Wilks, 1995). Within the British literature, two main models can be identified. The model developed by Rhodes and Marsh (1992b) identifies 'policy communities' and 'issue networks' as the two main types of interest group intermediation at the end points of a continuum. The term 'policy networks' is used in a generic sense to encompass all types. Policy network structures are classified along four key dimensions: membership, integration, resources and power. Under this typology, *policy communities* have the following characteristics: limited number of participants with some groups consciously excluded; a dominant professional or economic interest; frequent high quality interaction of all groups on all policy matters; continuity in relation to values, membership and policy outcomes; consensus in terms of values, ideology, and broad policy preferences; all participants have resources and the basic relationship is an exchange relationship; the distribution of resources is hierarchical so that leaders can guarantee the compliance of their members; there is a balance of power between members and although one group may dominate, it must be a positive sum game if the community is to continue. In contrast, *issue networks* are characterised by competition among a large number of members encompassing a range of interests; fluctuating interaction and access; absence of consensus and the presence of conflict; consultation rather than bargaining; and unequal power between participants in which many have restricted access and limited resources (Rhodes and Marsh, 1992b: 186-187). Rhodes and Marsh (1992b) stress that this typology should be used only as a diagnostic tool as no policy area will conform neatly to either type of policy network.

Stephen Wilks and Maurice Wright (1987) offer an alternative conceptualisation of policy networks which stresses the need to disaggregate to sub-sectoral networks and places emphasis on interpersonal relationships. They draw distinctions between 'policy universe', 'policy community' and 'policy network'. The *policy universe* refers to the large population of actors or potential actors who share a direct or indirect interest in policy and may contribute to the policy process on a regular basis. Under their typology, *policy communities* are more disaggregated systems of actors drawn from the *policy universe* who share a common interest in a particular policy area and interact with one another to shape policy. The *policy network* is the linking process or the outcome of the interaction within a policy community or between a number of policy communities over particular policy issues, problems or functions (eg. budgeting, auditing, or planning). In effect, policy issues, problems and functions provide the occasion for a policy network.

Wilks and Wright (1987) argue that their model, which treats the concepts of 'community' and 'network' as separate, has several advantages. Firstly, policy subsystems always generate policy communities but these do not always generate networks. Secondly, it recognises that the members of a policy network can be brought in from different policy communities within the same or different policy areas. Thirdly, it enables researchers to identify those members of a policy community who are excluded from a policy network. Fourthly, their model also stresses that all policy issues in a sub-sector are not necessarily dealt with by one network, thus allowing comparison of membership, function, and characteristics of networks whose membership is drawn from the same policy community (Wilks and Wright, 1987; Wright, 1996).

In relation to drugs policy during the 1980s and 1990s, Berridge (1996a; 1997) identifies a drugs policy community consisting of revisionist doctors, researchers, drug agencies and civil servants. In my analysis, I will be examining the extent to which this 'policy community' and others have taken interest and become involved in penal issues. Policy networks at the sectoral level often play a role in shaping the membership, values and outcomes of sub-sectoral policy networks (Cavanagh et al, 1995). Drawing on the model offered by Wilks and Wright (1987) emphasising the sub-sectoral level of policy, I am concerned with intersection between drugs and penal policy, the emergence of policy

networks around prison drug issues and how these have changed and evolved over the various phases of policy development from 1980. Over time, policy networks have interacted over several different issues such as release and throughcare, drug treatment and detoxification, HIV/AIDS and harm reduction, security and control issues, and mandatory drug testing (see Table 1.1).

Table 1.1 Policy communities and policy networks (the Wilks and Wright (1987) typology adapted to prison drugs policy)

Policy level		Policy actors
Policy area	<i>Health, Criminal Justice</i>	Policy universe
Policy sector	<i>Drugs, Prisons</i>	Policy communities
Policy sub-sector (focus)	<i>Prison drugs policy</i>	
Policy issue	<i>eg. Throughcare Treatment HIV/AIDS Security/control Mandatory drug testing</i>	Policy networks

Although the network approach has been widely applied, it has been subject to various critiques (see Hogwood, 1987; Atkinson and Coleman, 1992; Kassim, 1994; Dowding, 1995; Blom-Hansen, 1997; John, 1998). In particular, the network approach fails to provide an account of why relationships form and change between the various actors and how power is exercised. It also fails to provide an adequate account of the role of the state and institutions and the impact of political discourse, ideology and cognitive frameworks of network members (Atkinson and Coleman, 1992; Kassim, 1994). There is often no clear indication of boundaries delineating where networks begin and end or who is excluded and included (Kassim, 1994). Most analyses of networks have tended to focus on whole policy sectors, thus neglecting the sub-sectoral level of policy. Moreover, issues tend to overlap with other issues and interact with policy solutions. They tend not to remain within one policy network, but often intersect with the interests and concerns of other networks (Hogwood, 1987). Because policy networks change over time, Wilks (1995) has outlined the need to provide more dynamic, longitudinal

analyses, rather than snapshot analyses of one particular period.

Atkinson and Coleman (1992) argue that two key questions should be asked in relation to policy networks, namely, who participates and who wields power? My analysis is concerned with the changing membership of policy networks around drug issues in prison. During the course of policy development, key roles have been played by drug agencies, penal reform groups, professional associations, the Prison Medical Service, researchers and government departments. The ACMD has produced two reports dealing with the prison system and has also been influential in shaping policy development (ACMD, 1980; 1996). Policy network analyses indicate that some members or organisations will be located at the 'core' of the policy system while others will occupy a position on the margins or 'periphery' (see Coleman and Skogstad, 1990; Marsh and Rhodes, 1992; Smith, 1993). The analysis will therefore focus on which organisations and individuals are included or excluded in the networks, which members gain access to the 'core' or remain on the 'periphery', and how these positions have altered over time.

Network approaches offer only a partial explanation of policy shifts and variation. There is a need to explore how interests, ideas, discourses, institutions and social, economic and political contexts interact and influence how networks operate over time. Several scholars have attempted to bridge some of the gap between network approaches and institutional arguments (see Skocpol, 1985; 1992; Smith, 1993; Pierson, 1994; Blom-Hansen, 1997) and this work provides a starting point in addressing some of the criticisms of the network approach discussed above. For example, Smith (1993:2) argues that the impact of groups depends on the interests of state actors and the types of relationships between groups and the state – policy networks – which exist in specific policy areas. Similarly, the 'new institutionalists' assert that institutions and patterns of governance matter by setting the parameters for action and establishing the rules of the game, by shaping group identities, goals, and choices and by enhancing the bargaining power of some groups while devaluing others (Skocpol, 1992; Pierson, 1994). Skocpol (1992) has cogently argued that politicians and civil servants are actors in their own right who are enabled and constrained by political organisations and possess the ability to make independent contributions to policy development. This capacity of the state to act

autonomously is dependent on the fiscal, judicial, and administrative capacities (Weir and Skocpol, 1985). However, it is often the case that governments need groups to develop and implement policy so they 'exchange access to the policy process for co-operation and thus establish a policy network' (Smith, 1993:59). Policy networks are therefore a means of increasing state autonomy. Smith (1993: 6) describes the reciprocal relationship between the state and groups in the following terms: 'group power depends on state recognition and state power depends on the support of groups'.

Drawing on the work of the 'new institutionalists', this research is concerned with the impact of institutions, structures and state actors in the development of policy networks and prison drugs policy. The key state agencies or institutions involved in this area have changed or been reorganised over time and include the Prison Service, the Home Office, and the Central Drugs Co-ordination Unit (now the UK Anti-Drugs Co-ordination Unit). The degree of state autonomy will also be explored by examining the discourses, interests, activities and influence of state actors - politicians and civil servants – over time. However, this is not to suggest that the state has a set of unified interests: policy may be the outcome of conflict between state agencies (Smith, 1993). The institutional contexts of other groups participating in the policy networks such as drug agencies, penal reform groups and professional associations are also significant in my analysis. The ideological foundations of these groups are important as these are brought to the policy network fora by their representatives. These ideas and discourses play a central role in how the drug issue in prison becomes defined and how policy alternatives are framed.

A particular focus of the thesis is to assess the role, influence and power of policy networks in prison drugs policy. The key concern is to explore their role in containing the central contradiction in policy development between treatment and punishment. This containment has been shaped by several processes such as how the drug issue in prison has been framed and defined; the relationship between research and policy; and the impact of shifts in the wider social, political and institutional context and related policy subsystems. These processes appear more or less dominant in the different phases of policy development. Each of these processes will be discussed and elaborated upon below.

The way in which the drug issue in prison has been defined and framed has shifted over the various phases of policy development and influenced policy outcomes. Defining social problems and framing policy agendas continues throughout the policy process. In order to understand a social problem, we must explore the process by which it came to be identified and defined as a problem (Becker, 1966). From a social constructionist standpoint, 'problems' are created by society and viewed as the outcome of a political process where certain groups are labelled by the powerful as 'problematic' or 'deviant'. In relation to drugs policy in prison, a key role has been played by policy networks in defining policy issues and problems. However, as Jock Young (1997a) has argued, the social constructionist perspective attempts the impossible in that it tries to explain the reaction against deviance separately from the deviance itself or the formation of social problems separately from the problems themselves. Thus, the reaction against drug misuse in prison cannot be bracketed off from the phenomenon itself. In left realism, the two sides of the dyad - action and reaction, the signified and the signifier, rule-making and rule-breaking - interact and shape each other (Young, 1997a). In my analysis, I will integrate these two processes by examining the reaction, framing and definition of the drug problem in prison as well as the nature and extent of the problem itself.

Martin Rein and Donald Schon (1993) offer a useful framework for analysing policy discourse¹⁵ which integrates facts, values, theories and interests. In their view, policy participants construct and make sense of problematic policy issues through a process of 'framing' which is defined as 'a way of selecting, organising, interpreting, and making sense of a complex reality to provide guideposts for knowing, analyzing, persuading, and acting' (Rein and Schon, 1993: 146). Policy issues are often framed in terms of severity, incidence, novelty, proximity and crisis (Rochefort and Cobb, 1993). These dimensions influence whether they will be placed on the policy agenda. Severity refers to how serious a problem and its consequences are perceived to be. It often helps if an issue

¹⁵ Rein and Schon (1993:145) define policy discourse as the 'interactions of individuals, interest groups, social movements, and institutions through which problematic situations are converted to policy problems, agendas are set, decisions are made, and actions are taken.'

affects a large number of people or has a devastating impact on a few people. Incidence refers to the number of people affected or at risk of the problem and whether the problem is perceived to be growing, stable or declining. Novel, unprecedented or trailblazing issues have the capacity to win attention quickly. Proximity refers to whether the problem is perceived to be personally relevant or of general social concern. Problems which have reached 'crisis' or emergency proportions are also given priority on policy agendas. However, the distinction between 'problem' and 'crisis' is not always clear. Advocates often use the rhetoric of crisis to stress the urgency of an issue. This is particularly the case in relation to the areas of prisons and drugs. References to the 'penal crisis' and the 'drugs crisis' have become enduring features within these policy lexicons.

The populations affected by the problem are also defined. In particular, distinctions are drawn between populations who are perceived to be deserving versus undeserving, legitimate versus illegitimate, worthy versus unworthy, familiar versus strange, and sympathetic versus threatening (Rochefort and Cobb, 1993). Characteristics such as race, gender, class and age are also considered. Often, deviants and other excluded groups do not receive equivalent considerations. In definitional terms, it could be argued that drug misusing prisoners are labelled as doubly 'deviant' in that they are viewed both as criminals and drug misusers, and therefore defined as undeserving, illegitimate, unworthy, strange and threatening. Moreover, the discourse of 'less eligibility' has always influenced the development of penal policy and ensured that the conditions and services available to prisoners are not superior to those available to the working classes or they will not be deterred from committing crime (Melossi and Pavarini, 1981). The way in which affected populations are perceived by policy-makers and the public are therefore crucial in terms of determining the balance between care and control in policy design (Rochefort and Cobb, 1993).

Policy issues and problems are malleable and open to competing interpretations, definitions and solutions. Each framing of a particular policy terrain is likely to select and name different features of the problematic situation which may lead to conflicting frames. Rein and Schon (1993) argue that the 'institutional embedding' or the structural location

of the different policy actors will affect the way in which a policy issue is framed. Each professional group within the penal system have their 'own jurisdiction, career structure, interests and ideologies' (Garland, 1990: 182). In relation to prison drugs policy, the 'institutional embedding' of the various participants will influence their framing of drug issues, the nature of their discourses and the types of policies and courses of action advocated. Framing could highlight issues around treatment, harm reduction, release and throughcare, security, control, punishment or drugs testing.

It is important to examine the naming and framing of policy issues over time in order to identify 'frame shifts' (Rein and Schon, 1993). It will be clear from the analysis which follows that four frame shifts can be identified over the phases of prison drugs policy development. In broad terms, as the extent and nature of drug misuse in prison became officially acknowledged by civil servants, politicians and prison governors, the framing of the issue shifted from being defined primarily as a medical issue and a problem of treatment for individual prisoners to a control, order and enforcement issue and a problem for the institution.

Role of research, evidence and knowledge

Research can play an important role in sensitising policy networks to new issues and turn what were regarded as 'non-problems' into 'problems' (Weiss, 1977b: 16). This thesis is also concerned with the role of evidence, research and knowledge in the recognition, definition and framing of drug issues in prison and in the development of policy, implementation and change. The relationship between research and policy-making has been the subject of much scholarly debate. Several authors use the distinction made by Morris Janowitz (1972) between the engineering and the enlightenment model in their analyses of the research-policy relationship (see Bulmer, 1982; Abrams, 1984; Finch, 1986; Booth, 1988; Petersilia, 1991; Rist, 1994). Within the engineering model, the impact of research on policy is direct, specific and solves practical problems, while the impact is less direct, more diffuse and cumulative in the enlightenment model. It is widely held that the enlightenment model adheres more closely to the way in which most

forms of research impact upon the policy process compared to the engineering model.

Carol Weiss (1986) argues the term 'research utilisation' is associated with a variety of different meanings and interpretations. Including the enlightenment model and two variations of the engineering model, she identifies seven different models which will be useful in framing my analysis of the role of research in prison drugs policy: knowledge-driven, problem-solving, interactive, political, tactical, enlightenment and research as part of the intellectual enterprise of society. The first two models correspond to the engineering model as identified by Janowitz (1972). The *knowledge-driven model* is derived from the natural sciences and assumes a linear application of research findings. Here, basic research highlights an opportunity, applied research is conducted to define and test these findings, appropriate technologies are then formulated, and finally application occurs. It assumes that the existence of knowledge will drive it towards development and use. Few examples of the knowledge-driven model can be found in the social sciences (Weiss, 1986). The *problem-solving model* also offers a linear account of research utilisation. Here, research directly influences policy choices and decisions by providing evidence, information and knowledge which help to solve and illuminate a particular policy problem. This can be achieved by drawing on existing research, data and information or by commissioning new research to fill gaps in knowledge. Although this model is the most common perception of research utilisation, it is rare to find examples of research having such a direct effect on policy decisions (Weiss, 1986).

Within the *interactive model*, information is sought not only from researchers, but from a range of actors in the policy process including politicians, civil servants, journalists, interest groups, practitioners, planners, and clients. There is no linear relationship from research to policy decision, instead the process consists of a 'disorderly set of interconnections and back-and-forthness that defies neat diagrams' (Weiss, 1986: 35). Members of policy networks pool their knowledge, intelligence and perspectives in order to define and make sense of the problem. Research is but one element of a process which involves political insight, experience, pressure, technology and judgement (Weiss, 1986). In this model, researchers can play an important role in promoting and acting as partisans for their research (see Donnison, 1978; Booth, 1988; Bartley, 1996). Tizard (1990: 438)

argues that researchers need to ensure that their findings and ideas progress through crucial 'gateways' if they are to come to the attention of policy-makers and influence the policy process. It is therefore important to recognise the 'micro-political activism undertaken by many scientists, regardless of their policy orientations at the macro level' (Bartley, 1996: 23).

In many cases, various interests and ideologies coalesce to pre-determine the positions of policy-makers on particular issues or problems. Under the *political model* of research utilisation, new research and evidence is therefore unlikely to influence or change these positions. It therefore plays a legitimisation or justification function for particular policy decisions. Research which confirms the existing arguments is used by advocates as 'ammunition' to attempt to neutralise opponents and persuade those who doubt their position (Weiss, 1986). The political model often masquerades as the problem-solving model (Tizard, 1990). A variant of the political model is the *tactical model*. Here, the findings of research are unimportant, rather it is mere existence of research or the notion of 'research in progress' which is considered paramount. When faced with demands for action on particular issues, governments are able to delay responses by playing the 'research card' (ie. they are awaiting the results of research). Social researchers and the research they produce can also be used to deflect criticism away from government in relation to unsuccessful policies (Weiss, 1986). As Tizard (1990) argues, employing research as a tactic results in many research reports remaining unread and collecting dust on the shelves of government departments.

Research can also enter the arena of policy through a process of 'enlightenment' or 'indirect diffusion' (Weiss, 1986). Within the *enlightenment model*, single pieces of research or even a body of related studies do not directly impact upon policy, rather it is the effect of cumulative research and information over time which sensitises policy-makers to new issues and shapes the way in which problems are defined and framed. However, the role of research through the process of enlightenment can have a dramatic impact and can help to redefine the policy agenda. Although the enlightenment model often corresponds most closely to the way in which research informs policy decisions (see Weiss, 1980), it does have several limitations. For example, there is no filtering

process by which inadequate or invalid research is screened out. Many research findings will also fail to penetrate the policy arena, while others take such long periods that they are out of date or irrelevant by the time they are considered. Finally, the more research conducted on a particular issue, the more complex the implications become for policy decisions. The direction for policy therefore becomes less clear.

Research can also be viewed as *part of the intellectual enterprise of society*. Here, research is not viewed as an independent variable affecting the policy process, but rather as a dependent variable. As Weiss (1986: 39) argues, 'social science and policy interact, influencing each other and being influenced by the larger fashions of social thought'. Policy interest often sets the parameters of research, influencing which social issues or problems are studied. One of the barriers to exploring the relationship between research and policy is that they are often treated as separate and self-contained activities. Smith (1992) also emphasises the reflexive relationship between policy and research and argues that research and policy are processes which constantly interact and shape one another.

It is important to acknowledge that different types of research correspond to different types of models (Tizard, 1990). In my analysis, I aim to draw on the various models discussed above to explore 'research utilisation' within the phases of prison drugs policy development. The penetration of evidence into the policy-making arena is not automatic and depends on various factors. These factors have been discussed by various commentators and include the nature, type and quality of the research, the characteristics and institutional location of the researcher, the characteristics of the policy-making apparatus¹⁶, the extent of the gap between the worlds of the researcher and policy-maker, and whether research is discovered and publicised (see Hall et al. 1975; Bulmer, 1978; 1982; Finch, 1986; Booth, 1988; Tizard, 1990; Petersilia, 1991). The political, economic and social context of research utilisation is also important.

During the period under review, research in all areas of public policy was influenced by the 1971 Rothschild report which established the distinction between the roles of client

¹⁶ If policy-making is not centralised, it is more difficult to influence the policy process with research (Tizard, 1990).

and research provider and a reorientation towards planning, efficiency and relevance. By the 1980s and 1990s, reflecting the market values imposed by the Conservative government, research had become a commodity and there was growing pressure for more accountability and tighter project management. This has had serious consequences for the production of independent research and new knowledge (see Samson and South, 1996; Shove, 1996; Walker, 1989). Due to changes in research funding and the way research is now commissioned and conducted, researchers are under pressure to ask particular questions and produce research which intersects with a particular research programme or agenda (Bartley, 1996). Much research has become atheoretical and preoccupied with existing policies, rather than concerned with discovering and theorising about new problems. Although there were increased opportunities for criminological research in the 1980s, the attempt to integrate research with wider theoretical frameworks declined, leading to the rise of what Young (1986) has characterised as 'administrative criminology'.

The impact of related policy subsystems and the wider context

My analysis also aims to explore the impact of other policy subsystems and the wider political, social and institutional contexts on the development of prison drugs policy. The way in which the drug issue in prison is framed, debated and the setting out of policy options is influenced by wider forces. Rein and Schon (1993:154) emphasise that the framing of a policy issue always occurs within a 'nested context'. In this view, policy issues emerge in connection with governmental programmes, which exist within a wider policy environment, which is part of a broader political, social and economic setting, which is situated within a historical era. Features of this context shift and impact on each other, often resulting in the reframing of a policy issue. Rein and Schon (1993) distinguish between four nested contexts: internal, proximate, macro and global.

The *internal context* refers to the policy program itself and changes in its own personnel, sponsors or clients. In this analysis, changes within the internal structure and organisation of prison drugs policy and the membership of policy networks will be

explored. The *proximate context* refers to the changes in the policy environment in which the particular program operates (Rein and Schon, 1993). Prisons drugs policy can be viewed as the outcome of interaction between three main public policy subsystems or sectors: penal policy, drugs policy and social policy. The distinction and separation between these areas of policy is artificial as they overlap in both practice and theory. As Hill and Bramley (1986) argue, it is difficult to define social policy and draw boundaries around it. A conventional classification of social policy areas would include social security, health services, welfare or personal services, education and housing. Traditionally, penal policy and the criminal justice system have not been included in the realm of social policy, but have been placed in a separate and distinct category of public policy (Hudson, 1993, Hill and Bramley, 1986). Similarly, drug issues have tended to be the province of the medical-scientific community and have therefore occupied a marginal position within social policy (MacGregor, 1998b).

However, there are aspects of the penal system which are concerned with the general welfare needs of prisoners, such as probation, specialist services delivering drug treatment and counselling, as well as other agencies providing services in prison and on release. Hudson (1993) has illustrated the cleavage and continuity between social and penal policy. Similarly, MacGregor (1998b) argues that the development of drugs policy in Britain, once the domain of the medical community, has also begun to converge with other areas of social policy. As drug misuse has become 'normalised' within communities, policy responses have become more congruent to the way in which other 'social problem' groups are dealt with. Thus, the concept of 'policy transfer' can be stretched to refer to the adoption of policies or ideas from one policy area or subsystem to another. Kingdon (1995:191) refers to this process as 'policy spillovers' where new principles, ideas or policies are transferred or spill over to adjacent policy areas. The internal and proximate contexts can also be shaped by 'policy transfers' from one country to another. In the case of prison drugs policy, policy initiatives from the United States, such as drugs testing and certain types of treatment programmes, have played important roles in policy development. Historically, prisons and the criminal justice system have not had prominent roles in British drugs policy, however, these areas have become increasingly interconnected over time. Although my analysis of prison drugs

policy concentrates mainly on the impact of developments and changing discourses within penal and drugs policy, the growing convergence between these areas with wider social policies is also important. The analysis is also concerned with the reverse process or the extent to which developments in prison drugs policy have impacted upon or been transferred to adjacent policy areas.

The *macro context* refers to wider changes in the overall direction of policy and social, economic, political and institutional change, while the *global context* refers to those at the broadest level such as changes in the historical eras in which reframing may occur (Rein and Schon, 1993). From 1979 to 1997, significant changes took place in prison drugs policy under the Conservative governments of Thatcher and Major. This development has occurred within a broader context of turbulent political, historical, economic and social change heavily influenced by the ideologies of the New Right. Thatcherism was underpinned by a combination of neo-liberalism and neo-conservatism. Neo-liberals emphasise the free market, freedom, choice, liberty, limited or minimal state, and the primacy of the individual, whilst neo-conservatives emphasise authority, order, stability, tradition, the family and morality. As several scholars have argued the ideologies of the New Right informed Conservative policy, but often in inconsistent and contradictory ways (see Brown and Sparks, 1989; Atkinson and Savage, 1994; Cutler and Waine, 1997). For example, in some policy areas such as welfare provision, controls on public spending and minimal state intervention were advocated, while in other areas such as law and order, resources and state intervention increased.

Since 1979, developments in public policy have challenged the traditional 'public administration model' of welfare delivery which was based on a bureaucratic structure, professional domination, accountability to the public, equity of treatment, and self-sufficiency (Butcher, 1995). Under the Conservative governments, there was increasing emphasis on a more managerialist and consumerist orientation to public sector organisation. The 'new public management' which emerged emphasised value for money, a performance-based culture, the disaggregation of large bureaucratic organisations, promotion of greater competition through the use of market-type mechanisms, and customer orientation (Butcher, 1998: 25). Cutler and Waine (1997: 6) outline the key

dimensions of public sector managerialism which include an hierarchical approach where targets are set and monitoring is controlled from the top; an assumption that the structure is universally valid and can be applied to both the private and public sectors; the need for performance monitoring and the assumption that it is possible to develop valid management information; and tension within professional practice as a result of the hierarchical approach.

Initially, the criminal justice system was believed to be safe from these managerialist tendencies. It was not subjected to the large-scale reforms of health and education. This was related to the increase in expenditure on law and order during the 1980s, the opposition and power of key professional groups such as the judiciary and chief constables, the dispersal and lack of co-ordination between the various agencies in the criminal justice system, the lack of alternative providers in the market, and the absence of 'consumers' (ie. there was no prospect of reconceptualising offenders as 'consumers') (James and Raine, 1998; McLaughlin and Muncie, 1994). However, the managerialist agenda was soon applied to the problems of crime and punishment in the form of financial controls, performance monitoring, and organisational design. For example, several prisons were contracted out, contracts were awarded for prison escort duties, the operation of prisons and the administration of the Crown and County Courts were hived off into Next Steps agencies, partnership and multi-agency structures were established, aggregate monitoring systems were introduced, and management by objectives or performance indicators were introduced across the whole criminal justice system. It is within this context that prison drugs policy began to be developed and formulated in a more explicit way, taking on the attributes of managerialism.

Shifts within these nested contexts will be an important feature in the framing and reframing of drug issues in prison. However, Rein and Schon (1993:155) also argue that the 'reframing of issues can shape the contexts on which that reframing is dependent'. This links into the arguments of the new institutionalists which emphasise the role of 'policy feedbacks' or the ways in which previously established policies or inherited policy structures shape subsequent political processes (Skocpol, 1992; Pierson, 1994). In this view, policy is treated as both an independent and dependent variable. Skocpol

(1992:58) argues that policies have feedback in two major ways. Firstly, policies transform and expand the capacities of the state or alter the administrative possibilities for future initiatives. Secondly, new policies affect the social identities, goals and capabilities of the groups involved in politics. In some cases, groups will have a stake in the expansion and continuation of particular policies while in others, groups may seek to repeal or reorient policies (Skocpol, 1992). The policy feedback dynamic underlines the importance of taking an historical approach in order to explore how prison drugs policy had unfolded over time.

Conclusion

The review of literature on drugs and prison has indicated that the processes involved in the development of contemporary prison drugs policy have not been adequately addressed by existing scholarship. The general review of literature in the areas of drugs and penal policy development has highlighted various themes, concepts and issues which are relevant to my analysis of prison drugs policy. I have identified several interconnecting themes which will run through this analysis: the role and influence of the policy network in containing the contradiction between treatment and punishment and the way in which this process of containment has been shaped by the framing of the drug issue in prison; research, evidence and knowledge; and the wider policy, political, social and institutional contexts. The framework employed to develop these themes and concepts draws upon the policy sciences literature. Although this literature has been used extensively in other areas of public policy, it has seldom been used in the areas of drugs, penal and criminal justice policy.

The next chapter will elaborate on the research methods and design which were employed to investigate the role of policy networks in the development of prison drugs policy.

Chapter Two

Research design and process

Introduction

This chapter explains my choice of research design and methodological framework for examining the processes involved in the development of prison drugs policy. In order to explore how policy developed over time, which factors influenced this development and the role and influence of policy networks in this process, a qualitative case study was viewed as the most appropriate design. The main methods employed in the case study were semi-structured interviews with key actors in the policy process and an analysis of policy and other documents. The chapter begins with a discussion of the political dimensions of the research problem, explores the value of the qualitative and case study approach in researching the policy process, and then describes the methods of data collection and analyses employed in this piece of research. The final part of the chapter provides a reflexive account of my experiences in undertaking this study.

Political dimensions of the research problem

As we saw in Chapter One, existing research on drug issues and prisons has tended to focus on the *prisoners themselves*, emphasising prevalence issues, risk behaviour and their 'performance' in relation to the new rules, tests and regulations of the most recent prison drugs strategies. In contrast to other disciplines such as political science and history, this tendency for researchers to favour studying marginal groups is an enduring characteristic of sociological research, particularly within the spheres of criminology and the sociology of deviance (Liazos, 1972; Punch, 1986; Yeager and Kram, 1995; Neal, 1995). The tradition within criminological research has been to concentrate on offenders and deviant populations. Similarly, drugs research has been dominated mainly by studies of drug takers and drug addicts (see for example Becker, 1963; Young, 1971; Agar,

1973; Rosenbaum, 1981; Burr, 1987; Parker et al; 1987; Pearson, 1987a; Ditton et al, 1991; Parker et al, 1998). The focus of research has rarely been on those in positions of power¹ such as the police, Crown Prosecution Service, Customs and Excise, and the probation and prison services or those involved in the formulation of the policies drug takers and drug addicts are subject to. Thus, the focus generally has been on the 'objects' of policy, rather than on the policies themselves or the policy-makers and professionals working within this area.

Ethnography has generally been defined by 'a radically parochial imaginary of the margins' (Harding, 1991: 376). There are valid and important reasons for this preference to study the 'margins' rather than the 'centre' of society. In some cases, social scientists have preferred to study the powerless² and the disenfranchised because they believe that this will empower them (Hertz and Imber, 1995). Similarly, it is important to give credence and legitimacy to what Foucault (1980: 82) called 'subjugated knowledges' or those which 'have been disqualified as inadequate to their task or insufficiently elaborated: naive knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity'. There are however important dangers in this perspective as well. One consequence of focusing on powerless groups is that it may help to perpetuate and increase their marginalisation, resulting in further stigmatisation and exclusion. Therefore by focusing only on the powerless or those on the margins, it contributes to making these cultures or groups appear particularly problematic (Gusterson, 1995). For example, the skewed focus in drugs research has attempted to 'normalise' the culture of the anti-drugs campaign and 'problematise' the culture of the drug takers and misusers. Another consequence of the preoccupation with studying

¹Important exceptions are Mike Collison's ethnographic analyses of a force level drug squad (see Collison 1995) and the work of Vincenzo Ruggiero and Nigel South on drug use, markets and trafficking in Europe which employed a triangulated methodology involving interviews with a wide range of actors such as ex-and current users, user-dealers, distributors, social workers, drug agency staff, police and probation officers and Customs and Excise staff (see Ruggiero and South, 1995).

²The use of the dichotomies powerless/powerful; excluded/included; margins/centre; subordinate/superordinate (Becker, 1967); studying up/studying down are problematic and must be contested. As Neal (1995) argues such terms are vague and imply that powerless and oppressed groups are passive. This cannot account for situations in which such groups become powerful and move from the margins to the centre or when powerful groups lose their power and move from the centre to the margins.

‘down’ is that in the case of drug addicts it legitimates them as ‘knowing subjects’, but it also turns them into ‘known objects’. As Gusterson (1995:193) concedes, ‘...to be studied is to be vulnerable’. There is therefore a need to impose this scrutiny upon elite populations - the rich, the privileged, and the powerful. In the case of drugs and prisons research, it is necessary to study those who are in positions of power in relation to the policy process.

Politics has an impact on all social research influencing the focus, aims and objectives, design, implementation and outcomes (Punch, 1986; Guba and Lincoln, 1989). The relative lack of research on the powerful poignantly illustrates the reality of the political research agenda (Neal, 1995). The focus on the powerless in some types of social research is inextricably linked to the state and its policies. As Hunter (1995: 167) argues, ‘this imbalance in research is often benignly motivated and legitimated in terms of the need for knowledge to develop ameliorative and reformist programs to solve whatever are at the moment defined as the prevailing social problems of the masses’. The lack of knowledge and research on the powerful contributes to mystifying their roles and therefore maintains their position of privilege in society. Research on these groups has the potential to expose the reach of power, so that those subject to it can understand it. It thus becomes a political act in which researchers gain knowledge from and about the powerful and disseminate this knowledge more broadly within society (Hunter, 1995; Hertz and Imber, 1995). In addition, a better understanding of methodologies for research on the powerful may begin to challenge that position (Ostrander, 1995).

The existing research on drug issues and prison has tended to favour a quantitative methodological approach to explore various aspects of the policy, including the proportions of positive mandatory drug tests and prevalence rates for drug misuse and HIV risk behaviour. Despite greater access to conduct research on drug issues within the prison system, it remains a very politically sensitive area to study. The difficulties in conducting research into sensitive policy areas have the greatest impact on qualitative and ethnographic projects (Pollitt et al, 1992). As political constraints often determine the focus and content of research, they also can determine how research is conducted and which methods are used. In order to provide an in-depth analysis of the processes

involved in the development of prisons drugs policy from the perspective of the policy networks engaged in this area, a qualitative case study design was seen to be the most suitable to facilitate this overview.

Research design

The value of the qualitative approach in researching the contemporary policy process

What constitutes a ‘case study’ has been the subject of much debate (Stake, 1994). The definition of ‘case’ has been contested and defined in various ways by different researchers. Moreover, original definitions of the ‘case’ can alter during the course of research and can change depending on the methods employed within the study. Case studies should not be viewed as a ‘methodological choice, but a choice of object to be studied’ (Stake, 1994: 236). Creswell (1994: 12) offers the following working definition of a case study: ‘the researcher explores a single entity or phenomenon (‘the case’) bounded by time and activity (a program, event, process, institution, or social group) and collects detailed information by using a variety of data collection procedures during a sustained period of time’.

Research questions which are prefaced by ‘how’ and ‘why’ lend themselves to the case study approach (Yin, 1989). In order to explore the role and influence of policy networks around drug issues in prisons, a case study of policy development at the national level was viewed as the most suitable strategy. The ‘case’ selected was prison drugs policy and the associated policy actors. Although my design does not conform neatly to the traditional types of case studies with their focus on selected examples of social entities such as individuals, communities, social groups, organisations and institutions, or events, roles and relationships (Hakim, 1987), it is a study of the ‘particular’. My aim was to develop a detailed, intensive knowledge about the development of prison drugs policy and the role and activities of policy networks since 1980, seeking out what is both common and particular about these processes. In order to highlight the uniqueness of prison drugs policy as a case, I studied and analysed its

nature; social, political, and historical background, setting and context; other cases through which it is recognised; and those actors through whom the case can be known (ie. policy networks) (Stake, 1994). Through my analysis, it became clear that prison drugs policy since 1980 could be divided into four main phases of development. In effect, my research constitutes a series of four case studies which enabled me to track changes in policy development over time.

Maxwell (1996:97) distinguishes between 'internal generalisability' which refers to the generalisability of a conclusion within the setting or group studied (ie. the case as a whole) and 'external generalisability' which refers to generalisability beyond that setting or group (ie. to other cases). Although my primary concern was not with 'external generalisability' or generalising from the findings of this research to other areas of policy, the case of prison drugs policy will reflect wider themes in society and have some relevance for other related areas, such as penal, drugs and criminal justice policy.

Within the case study, the methodological approach was qualitative. Qualitative research involves a complex web of terms, concepts and assumptions as well as a range of philosophical underpinnings and methodological techniques (Denzin and Lincoln, 1994; Mason, 1996). Although it cannot be reduced to a simple definition or set of principles, Mason (1996) suggests qualitative research has several common elements. Firstly, it is grounded in the interpretivist sociological tradition which focuses on how the social world is interpreted, understood, experienced or produced. Secondly, qualitative research is based on flexible methods which are sensitive to the social context in which data are produced. Thirdly, it is based on methods of analysis and explanation which involve understandings of complexity, detail and context (Mason, 1996: 4). Qualitative approaches are particularly well suited to studies which aim to increase understanding of the perspectives and meanings of the participants, the context within which the participants act, and the processes by which events and actions take place (Maxwell, 1996). For these reasons, qualitative techniques were most appropriate to facilitate my research aims and questions which focus on the roles and perspectives of key actors in the policy networks around drug issues in prison, the context of policy-making, and the processes involved in policy development.

Qualitative research has been criticised, resisted and challenged on many different grounds illustrating the politics embedded within this discourse (Denzin and Lincoln, 1994). It has often been termed 'soft', 'unscientific', 'subjective', and 'biased'. Conversely, quantitative research has been described as 'hard', 'scientific', 'objective', and 'value free'. It can be argued that qualitative research has two main purposes: 'a commitment to some version of the naturalistic, interpretative approach to its subject matter, and an ongoing critique of the politics and methods of positivism' (Denzin and Lincoln, 1994: 4). It is this critique of the positivistic project and political terrain which lies at the heart of the resistance to qualitative studies. Qualitative research can be viewed as an assault on the positive sciences and an attack on reason and truth (Denzin and Lincoln, 1994). The resistance to qualitative studies is prominent in the policy arena. The contribution of qualitative research in studying policy processes remains in the realm of the potential, rather than the actual (Finch, 1986; Rist, 1994). Informed through a positivist framework, policy-makers and practitioners often view qualitative research with scepticism and question its validity (Hakim, 1987; Pollitt et al, 1992). They tend to be attracted by the perceived political neutrality of the quantitative approach and are often seduced by research which produces 'hard facts', 'scientific' evidence, and the all important quotable statistics. In order for qualitative methodology to be accepted by policy-makers as a 'proper' way of conducting research, there is therefore a need to increase their understanding of the qualitative tradition and its value and to forge linkages between qualitative researchers and those working within the policy arena (Rist, 1994).

Pollitt et al (1992) argue that positivistic research models are of limited use in the investigation of contemporary policy and qualitative approaches offer distinct advantages. For example, quantitative measures can provide us with important descriptive data, but do not give us information or access to meanings and choices in the policy process which the qualitative approach can provide. Therefore, 'we may know what happens but not, in intersubjective terms why' (Pollitt et al, 1992: 58). There is also the danger with quantitative studies, which stress inputs, outputs, indicators and measures of performance, of forcing complex processes into preconceived categories and assuming that the policy process is linear. Qualitative methods can be used to delve into

parts of the policy process which quantitative methods cannot reach. They have the potential to explore innovation, originality, complexity, interactions, conflicts and contradictions. Moreover, such approaches can focus on broad questions, rather than narrow ones. In terms of ethics, qualitative approaches also offer advantages over quantitative methods as there is a commitment to ground interpretations in the perceptions of those studied (Pollitt et al, 1992), thus producing more authentic accounts. Even if the researcher is critical of the viewpoint expressed by those studied, this commitment is important in order to increase understanding. As a key policy player pointed out to me at the end of an interview:

It's easy, particularly for academics...I'm not having a go at you, but it's the easiest thing in the world to stand on the sidelines and say, 'What are they doing that for? They should have done this and they should have done that, and they should have done the other. What's all this going on here?' It's entirely necessary for someone to be doing that, because we're all in the midst of doing it and sometimes we can't see the wood through the trees. But it's also helpful that the academic recognises that the person who is actually trying to get on and do it is actually trying to do their best in trying circumstances.³

Although it is not easy to stand on the sidelines as this individual argued and it is necessary for researchers to make such challenges, the importance of understanding and recognising the viewpoint and position of those being studied is stressed. Qualitative research and its associated techniques make this possible.

It is necessary to build rigour into qualitative research designs and to ensure that the procedures used to generate data are robust. Maxwell (1996: 87) uses the term 'validity' to refer to the 'correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account'. This conceptualisation of validity does not imply the existence of any objective truth to which an account can be compared. Within a qualitative research design, validity is concerned with strategies used to rule out 'validity threats' or alternative explanations (Maxwell, 1996). Various scholars have provided lists of tactics, tests or strategies for assessing validity (see Guba and Lincoln,

³Interview (021) with spokesperson for professional association, January 1998

1989; Pollitt et al, 1992; Miles and Huberman, 1994; Cresswell, 1994; Maxwell, 1996). Such strategies do not verify conclusions, but test the validity and existence of possible threats to these conclusions. As Maxwell (1996: 92) argues, the key task is to search for 'evidence that challenges your conclusion or makes the potential threat implausible'. I was sensitive to validity threats throughout the research process and employed several tactics to test my findings. These included employing a triangulated research design (Denzin, 1970) involving both semi-structured interviews and documentary analysis; collecting data from a diverse range of individuals from various structural locations and with different points of view; searching for discrepant data or outliers and negative evidence in an attempt to falsify proposed conclusions; obtaining feedback from informants through 'member checks' (Guba and Lincoln, 1989) about data, theories and conclusions; and producing verbatim transcripts from interviews in an attempt to generate accurate and complete data.

Methodology

Documentary analysis

Documentary analysis is an important research tool either used on its own or as part of a triangulated research design (MacDonald and Tipton, 1993). Documentary records have great significance in contemporary social settings, particularly within the policy arena. Here, many of the key actors are involved in the production and consumption of written records and other types of documents (Atkinson and Coffey, 1997). However, documents represent artificial or partial accounts which cannot be taken at face value and require critical assessment. They are not neutral artifacts which provide an independent and transparent view of the social realities of organisational routines and decision-making processes, but mediums through which power is exercised (May, 1997). Documentary materials should be approached for what they are and what they are used to accomplish through an examination of their role in organisations, their type and form, and the cultural values attached to them. It is therefore important to attempt to get below the surface of documents by probing and analysing their construction, production and

consumption. In relation to drugs policy, Spear (1995: 13) argued for a fundamental rethink and the need to progress beyond the 'glossy government publications' and their associated political rhetoric. Within a context of increasing managerialism, Morgan (1997a) also notes how prison documents have become briefer and glossier over time, containing less meaningful information. Such documents tend to reduce the complexity of policy issues to very simplistic and crude levels.

In the area of prison drugs policy, there are several related types of documents which can provide a source of data at the national level. These are mainly 'official' documents which have been either written or influenced by those involved in the policy networks around prison drug issues. Under the typology of documents created by Scott (1990) which focuses on dimensions of authorship and access, 'open published documents of State origin' were the key documents used in my analysis. My research questions guided my selection and analysis of the documents. The main documents selected were those relating to prison drugs policy, penal and criminal justice policy, national drugs policy, and ACMD reports. Where available, I also collected and analysed annual reports and other relevant documentation produced by penal reform groups and drug agencies to explore the role of prison drug issues in their work (see the references for a list and categorisation of all the documents). Statistics relating to the prison population, drug addict notifications⁴ and drug offenders also formed part of this analysis in order to explore the extent and nature of the 'problem' of drugs in prisons over time through the use of 'official' indicators. Although these statistics have a number of limitations⁵, they

⁴ The Addicts Index was closed from April 1997. A number of factors were involved in this decision: the restricted range of drugs on which the Index focused meant that its usefulness had become limited as more and newer drugs such as 'ecstasy' and benzodiazepines become more popular; it was not being used by notifiers to check whether an individual presenting for treatment was already known and their treatment details; and the high costs associated with maintaining the Index (Home Office Statistical Bulletin, 1997: 3).

⁵ It is widely accepted that the number of notified drug addicts underestimate the total population of users of notifiable drugs for each year (ACMD, 1988; Plant, 1989). They refer only to those who have sought help with their addiction and mainly to those addicted to heroin, cocaine and methadone. Drug addict notifications by prison medical officers also underestimate the number of addicts for a number of reasons. For example, prisoners may be reluctant to reveal their addiction through seeking treatment due to fears of increased chances of cell searches, transfers to other prisons, being suspected of being HIV positive, and ill treatment from other prisoners and the prison authorities (ACMD, 1988; Tippell, 1989). Changes in the proportion of addicts notified by prison medical officers may reflect changes in the medical examination of prisoners on reception or poor compliance with notification regulations. The statistics relating to drug offenders are also limited in that they are only indirectly related to the

are used by policy-makers as one of the indicators of the extent of the drug problem (Mott, 1994). This was the first time that this collection of documents was marshalled together for analysis and interpretation in relation to the development of prison drugs policy.

Documentary analysis has been given inadequate attention in the research methods literature, particularly in relation to the practicalities of *how* to use and analyse documents (Platt, 1981a; 1981b; Scott, 1990; May, 1997). Drawing on the criteria of authenticity, credibility, representativeness, and meaning as proposed by Scott (1990), the quality of the evidence available through the documents in this study was assessed. Authenticity refers to a document's 'genuineness' or 'whether it is actually what it purports to be' (Scott, 1990: 19). In this sense, the documents used in this research can be categorised as 'authentic'. In order to understand the system of production, exchange and consumption of documentary materials, one needs to consider authorship and readership. When using official government documents, it is often impossible to determine the identity of those responsible for their production or the authors (Scott, 1990; Atkinson and Coffey, 1997). This anonymity is part of their 'facticity' and the official production of documentary reality. Although there may be an implied ownership of a document within a particular government department or agency, official documents do not usually have visible human agencies who express feelings, opinions and beliefs. As Atkinson and Coffey (1997: 59) argue, 'the absence of an implied personal author is one rhetorical device that is available for the construction of 'authoritative', 'official', or 'factual' accounts. It implies a reality that exists independently of any individual observer, interpreter or writer.' Within my analysis, I was interested in exploring the contribution of policy networks in the construction and production of the key documents relating to prison drugs policy.

The 'credibility' of documents refers to the extent to which the contents or evidence is distorted. It is important to consider the material interests of the author in producing a

prevalence of drug use. Those who used drugs before prisons will not necessarily have been imprisoned for drugs offences. Many drug users are sentenced to custody for offences related to their drug misuse (such as theft or burglary to finance their habits), rather than for possession or supply of drugs. Conversely, not all those sentenced to custody for drug offences will be drug misusers.

particular document. As Scott (1990: 23) argues, official documents are often 'based on a political interest in presenting one view rather than another, in transforming propaganda into apparently sincere 'information' or in justifying a particular choice of action'. The 'representativeness' of documents refers to whether they are typical of all the relevant documents. As discussed above, I was restricted to open published documents for a number of reasons. Civil servants are prevented by the terms of their employment from disclosing information gained during the course of their service without official sanction. At the extreme, some disclosures might amount to a breach of the Official Secrets Act. Furthermore, the Code of Practice on Access to Government Information has an exemption in relation to information relating to the development of policy.⁶ Finally, because the focus of the research was on the contemporary period from the 1980s, this further limited the range of documents available. Full disclosure of policy papers held by the Public Records Office may not be made for a lengthy period (typically thirty years) after the documents were created.

Finally, documents must be assessed in relation to their 'meaning'. The task of the researcher is to assess the meaning and significance of the contents of documents. There is diversity of approach in textual analysis including positivist, interpretative, feminist, semiotic, and critical perspectives. Scott (1990) offers an analytic basis for interpreting 'meaning' by drawing on the work of Giddens (1976) who has argued that studying documents in isolation from their social context deprives them of their real meaning. Within this framework, 'texts must be studied as socially situated products' (Scott, 1990: 34). Scott (1990) divides 'meaning' into intended, received and content meaning. The *intended* content of a text refers to the meaning the author intended to produce, while the *received* content refers to that which is constructed by the audience. Internal *content* intervenes between the intended and received meanings, but cannot be known independently of the intended and received meanings. Scott (1990: 35) concludes that the 'interpretation of a text cannot be separated from the questions of its production and its effects. The reading of a text is validated by relating it to the intentions of the author, and by taking account of the fact that its 'objective meaning' goes beyond these

⁶ This 'policy exemption' has been carried through into the Freedom of Information Bill introduced into Parliament in November 1999.

intentions, and also by relating the text to its audience’.

In analysing the content meaning, the focus is upon the relationships within the text or its parts to each other, the relationship of the text to other texts, and the relationship of the text to those who participated in its construction (Ericson et al, 1991: 48) It is therefore important to look beyond separate texts and analyse how they are related. Atkinson and Coffey (1997) refer to these relationships between texts as ‘intertextuality’, a term derived from the field of literary criticism. Within my analysis, each document was read through carefully and detailed notes were taken in relation to the focus of my research questions. I was interested in looking at the temporal dimensions of documents, the relationships between the various key documents and in exploring any shifts in the discourses around penal and drugs policy over time. In particular, I was interested in exploring how the problem of drug issues in prisons had been framed and defined within documents over time; the variations and changes in the conceptualisation and operationalisation of the concepts of treatment and punishment over time and between documents; how the tensions between these concepts were managed within the documents and if this had changed over time; the role of research in proposals for policy changes and the influence of the social, political and wider policy context. By analysing documents at the broader sectoral level (ie. documents relating to drugs, penal and criminal justice policy), I was also able to explore the influence of and interface between developments in wider policy subsystems and those in prison drugs policy.

The consultation lists of government departments are often used in research on policy networks as the key data source to explore membership and influence. As Cavanagh et al (1995) argue, this method is problematic and reveals little about the frequency and quality of the consultations. In order to operationalise policy networks and assess their influence, it is therefore necessary to interview both civil servants and interest groups. In this research design, semi-structured interviews were also conducted with key actors in the policy process, some of whom had been involved in the construction of policy documents. Documents can be used alongside other forms of data so that the biases of each can be understood and compared. For certain research questions, the public record and documentation is insufficient (Useem, 1995). Entering the worlds of those involved

in the policy networks and engaging them in discussion was the only way to generate rich and detailed data on their perceptions and experiences of the 'problem', the policies and the processes involved in their development. In the interviews, respondents did refer and speak either explicitly or implicitly about the documents which were included in this analysis. The methods were therefore interconnected with the documentary analysis informing the direction and focus of the interviews and providing historical and contextual dimensions to the interview data, while the interviews influenced further analyses and explorations of the documents.

Semi-structured interviews

The fieldwork involved interviews with a wide range of policy actors including civil servants working in government departments involved in the formulation and implementation of the 1995 prison drugs strategy; directors of drug agencies developing and providing treatment services within the prison system; directors of penal reform groups lobbying for reform within the prison system; and spokespersons for professional associations. This was the first time that this group of actors was interviewed about the processes and dynamics involved in the development of prison drugs policy. Those selected for interview were considered to belong to a central core of influence in the policy process. This group can be defined by their knowledge of prisons and drugs, their role as mediators within policy development and their regular interaction with one another over time. Within my analysis, 'policy-makers' refer to the administrative and professional civil servants within the various government departments with an interest in prison drugs policy. The rationale for interviewing policy-makers is that they play a central role in the formulation, implementation and management of the policies; liaise between Permanent Secretaries and their Ministers and other outside interests; and play a key role in steering between conflicting models of development. Drug agencies were considered important as they deal with the day-to-day realities of delivering care and treatment to drug misusing prisoners within the prison environment. Penal reform groups provided a perspective on the control of drug misusing prisoners within a wider penal reform agenda. Professional associations represent the interests of those involved with

the day-to-day implementation and delivery of policy. Although policy is shaped and influenced by others including government ministers, members of both Houses of Parliament, and journalists, these groups were not included in my analysis.⁷ Similar to Thom's work on the development of alcohol treatment policy (Thom, 1997; 1999), I chose to focus on the interaction between civil servants and the wider policy network.

An initial non-probability, purposive⁸ sample of key respondents was contacted. These individuals were identified through previous research I had been involved in⁹, consultation lists and other sources such as the media and annual reports of the relevant agencies and organisations. The principles of snowball sampling were also used. Each respondent was asked to identify others they felt should be interviewed. As the fieldwork progressed, the principles of theoretical sampling were employed (Glaser and Strauss, 1967; Strauss, 1987). This involved exploring additional aspects of policy development which became important during the fieldwork and through preliminary analyses, such as the impact of policies on the families and friends of prisoners, the impact of HIV/AIDS on policy development and the role of research in the policy process. The sample was thus extended to include various groups and individuals who could provide expertise in these areas.

Respondents were contacted initially by letter (see Appendix C for a copy of this document), which provided information about the research, outlined the aims and objectives, described what the interviews would entail, and ensured confidentiality and anonymity. They were asked to contact me if they agreed to be interviewed or wanted further information. In the majority of cases, respondents did respond to this letter, either themselves or through their personal assistants or secretaries. Those who did not

⁷ This is not to deny the power, contribution and influence of prisoners as 'knowledgeable agents' in policy debates (see Giddens, 1984; Medlicott, 1999) and the growing trend to research prisoners' roles in policy development.

⁸ Robson (1993:141-142) offers the following description of purposive sampling: 'the principle of selection...is the researcher's judgement as to typicality or interest. A sample is built up with enables the researcher to satisfy her specific needs in a project.'

⁹ In 1997, I was involved in the evaluation of Drug Action Teams (DATs) in England (see Duke and MacGregor, 1997). This research provided opportunities to meet and observe key players within the drugs policy community both through participation in three national conferences for DAT chairs and a conference for DAT coordinators and through the research process itself.

respond were followed up by a telephone call.

A total of fifty-two individuals/organisations were contacted by letter to be interviewed. Of these, nine contacted me by telephone to refuse interview. These conversations did however yield useful data, information and details. The reasons for refusal were varied including illness, change of employment, no longer working on the issue, and a perceived lack of knowledge about the issue. They did provide contact details of other potential respondents, sent documents which they thought might be helpful to the research and wished me luck with the project. Seven individuals/organisations did not respond either to my initial letter or to my follow-up phone calls. A total of thirty-seven individuals were interviewed. In four instances, two respondents were interviewed simultaneously. These were situations in which the 'lead' respondent felt it would be beneficial for my research to include another member of their organisation with particular experience or responsibility for prison drugs policy issues.

The interviews were retrospective in that they included discussions of the origins of prison drugs policy. It was difficult to access individuals who had been involved in policy-making in the very early stages as some of them had retired, changed jobs or died. In the final sample, twenty-one respondents could be described as having long-standing involvement in some aspect of the area under study. Most of this group had experience and knowledge dating back to the early 1980s which enabled them to reflect on the development of policy. Of course, there was the possibility of memory bias. Factual issues were cross-checked with documents and interviews were compared for consistency.

The network of individuals involved in prison drug issues is extremely small. For this reason it is necessary to withhold specific details about the organisation, agency, or department of each respondent in order to ensure that information is non-attributable. A striking characteristic of those interviewed was their varied backgrounds and experience in both the drug and penal fields. Many had been involved with different jobs and responsibilities over time relating to the areas of prisons and drugs. Some were holding multiple 'offices' at the time of the interviews. In effect, they could be described as

having ‘multiple personalities’ or ‘identities’ in this area of policy. For example, one respondent was a policy-maker, member of the ACMD, and had worked in a prison. Another was the director of a drug agency, member of the Parole Board and ACMD and had worked in a prison. This presented difficulties in classifying respondents because of their multiple roles and identities. In the end, they were categorised by their present paid position and their related experience and backgrounds were taken into account in analysing the interview material. The respondents fell roughly into four broad categories: policy-makers/civil servants, and representatives from drug agencies, penal reform groups and professional associations (see Table 2.1).

Table 2.1 Classification of respondents

Category	Number
Drug agencies	15
Civil servants	12
Penal reform groups	6
Professional associations	4
TOTAL:	37

The main criterion for selecting the respondents was seniority. They needed to be in a position within their organisation to influence policy formulation, implementation and development. The majority of respondents in the ‘civil servant’ category were senior civil servants¹⁰. The majority in the ‘penal reform’ and ‘drug agency’ categories were directors of their agencies or organisations. Those within the category of ‘professional association’ were spokespersons for their organisations. Of the thirty-seven interviewed, twenty-seven were men and ten were women. In terms of ethnicity, all respondents were white.

Qualitative interviewing or ‘conversations with a purpose’ (Burgess, 1984: 102) was considered the most appropriate technique for those interviewed. The interviews were

¹⁰The majority of the civil servants interviewed were Civil Service Grade 6 or members of the Senior Civil Service (formerly Grade 5 and above) .

characterised by an informal style, a thematic approach, and the assumption that data is generated through interaction (Mason, 1996). The objective was to focus on the respondent's experience and perspectives in order to generate as much qualitative data as possible. The interviews began with a discussion of the scope and purpose of the research, how the results would be used and disseminated, assurances that their comments would be treated with respect and accuracy and that all information would remain confidential and non-attributable. The main focus was to explore how the respondents viewed the development of policy in this area and the processes and factors influencing its development; how they defined the 'problem' of drug issues in prison, the methods used to manage it, why these methods were used, the appropriateness and effectiveness of these methods, and what they believed could work more effectively. In the majority of interviews, a core set of issues/questions were covered (see Appendix C for the topic guide/interview schedule used). In this sense, the interviews could be classified as 'semi-structured' as core themes were covered in all interviews and probes were used to seek further clarification and elaboration on key issues (May, 1997). Depending on the backgrounds, roles and responsibilities of the individuals, additional issues were also covered. The interviews were conducted in a very flexible manner so that respondents could discuss additional or alternative issues which they felt were important. This latitude in allowing respondents to develop their own perspectives and agendas is a central feature of qualitative research (Denzin, 1970) and has been developed and reinforced by feminist researchers (Oakley, 1981; Stanley and Wise, 1983; Finch, 1993).

Interviews were conducted over a six month period from the end of September 1997 to the end of March 1998. This period was marked by a number of political and policy changes which affected the research. After Labour won the general election in May 1997, a series of new policies were in the process of being formulated and implemented. For example, an anti-drugs coordinator was appointed in October 1997 whose mandate was to guide and coordinate the new national drugs strategy which was launched in April 1998. The prison drugs strategy was also in the process of being revised and was launched in May 1998. The timing of the fieldwork was important as prison drugs policy was on the cusp of change and entering a new phase. Respondents were therefore

positioned to both reflect back on the previous strategy and comment on the proposals for the new strategy. Other significant developments during this period included calls for a Royal Commission to explore the possibilities around drugs legalisation, the campaign in the Independent on Sunday newspaper for the legalisation of cannabis and the Home Secretary's son found dealing cannabis. These issues and events permeated the interviews through informal discussion and provided further insights into the politics and dynamics of the policy process.

All interviews were conducted face-to-face with the exception of one which was conducted over the telephone due to the time pressures of the respondent. With the exception of two, interviews took place in the office of the respondent. They were conducted during office hours and took between forty-five minutes and two hours to complete. The majority took approximately one hour. After each interview, I asked respondents to contact me if they wanted to add anything else to their interview. In some cases, they did ring me and provided further information, contact details of others they felt may be helpful or sent through further documents and reports they thought would be useful to the research. A thank-you letter was sent to each respondent, reiterating assurances of confidentiality and anonymity (see Appendix C for a copy of this letter).

Data analysis and interpretation

I have drawn broadly upon the principles of grounded theory methodology in analysing the data generated from the interviews and linking this to the documentary analysis (Glaser and Strauss, 1967; Strauss and Corbin, 1994). This approach is based on analytic induction or developing theoretical ideas from observations of the data themselves. Strauss and Corbin (1994: 273) describe grounded theory as 'a general methodology for developing theory that is grounded in data systematically gathered and analyzed. Theory...evolves through continuous interplay between analysis and data collection'. Generating theory and conducting research are therefore viewed as two parts of the same

process. A central feature of the grounded theory approach is constant comparative analysis (Glaser and Strauss, 1967). In practice, grounded theory methodology varies according to the focus of the research, its aims and objectives, the difficulties encountered during the fieldwork as well as the strengths and weaknesses of the researchers themselves. It has been adapted and developed by numerous researchers since Glaser and Strauss (see for example Wiener, 1981; Rosenbaum, 1981; Charmaz, 1990) and has been influenced by various contemporary trends and intellectual movements including ethnomethodology, feminism and postmodernism. Bryman (1988: 84) suggests three main reasons for the appeal of grounded theory approach: it allows theory to emerge from the data without losing touch with its empirical referent; it provides a framework to cope with the unstructured complexity of social reality; and it allows the development of categories and theories which are meaningful to the research subjects. Although grounded theory is frequently cited in the literature as the approach adopted, there are relatively few examples of 'genuine' application (Bryman, 1988; Bryman and Burgess, 1994). Strauss and Corbin (1994:283) outline the minimum requirements of research that they would define as 'grounded theory': 'the grounding of theory upon data-theory interplay, the making of constant comparisons, the asking of theoretically oriented questions, theoretical coding and the development of theory'. My research and analysis does adhere to these minimum requirements.

With the exception of five, all interviews were taped and transcribed verbatim. Of the five, one was conducted over the telephone, one respondent refused to be taped, and in three interview situations, the surroundings were not suitable for tape-recording. During these interviews, very detailed notes were taken and in some instances, verbatim quotes were noted. In addition to the interview transcripts and notes, I also kept a research diary which provided the space to record my progress during the fieldwork. The entries took the broad form of observational notes, methodological notes, theoretical notes and analytic memos as recommended by Schatzman and Strauss (1973)¹¹.

¹¹ According to Schatzman and Strauss (1973: 99), data should be categorised into 'distinct packages'. Under their scheme, observational notes (ON) refer to records of events experienced through watching and listening and contain very little interpretation; methodological notes (MN) refer to statements concerning methods, operational acts completed or planned, instructions and reminders to the researcher, notes regarding timing and so on; theoretical notes (TN) refer to 'self conscious, controlled attempts to derive meaning from any one of several observational notes' (Schatzman and Strauss, 1973:

As advocated by grounded theory methodologists, data analysis occurred simultaneously with the fieldwork (Glaser and Strauss, 1967; Strauss and Corbin, 1994). After approximately ten interviews, broad themes and categories emerging from the interviews were noted and a short synopsis was written. These initial categories affected subsequent fieldwork in two main ways. Firstly, the interview schedule was adapted and refined to focus more closely on the emerging themes and to gain greater theoretical sensitivity (Glaser, 1978). For example, more emphasis was placed on exploring the various influences on policy during the phases of development and the role of the policy network in containing the contradictions within policy. Secondly, as discussed above, the tenets of theoretical sampling were employed whereby additional respondents were identified as new themes and areas emerged from the initial interviews (Glaser and Strauss, 1967; Strauss, 1987). This process was repeated again after approximately twenty interviews were conducted. As the fieldwork progressed, I engaged in a process of 'member checks' (Guba and Lincoln, 1989) which involved testing out my ideas and theories on respondents and asking them for their views. Many respondents indicated that they were happy for me to contact them again for any clarification or expansion. In particular, I contacted three key respondents again when the four main phases of policy development emerged from the interview and documentary data. I was interested to confirm that these corresponded to their own views on the temporal development of policy.

At the end of the fieldwork, all interview transcripts and notes were carefully and systematically read again. All themes and categories emerging from the data were noted. Some had been derived from existing theory, literature, and the documents and had been covered systematically within the interviews (see Appendix C), while others had been generated spontaneously and were subsequently developed inductively during analysis. For example, the theme of the tension between medical and penal forms of control was derived from existing theory and literature, while those of 'policy transfers' and the various phases of policy development were developed inductively from the interview and documentary data. Key words, phrases and passages were then highlighted on the transcripts. These items of text were given codes or labels in the margins relating to the

101), and analytic memos enable the researcher to 'elaborate upon the inference, or tie up several inferences in a more abstract statement' (Schatzman and Strauss, 1973: 104).

categories and themes already identified. As Strauss (1987: 29) argues, the goal of coding is to 'fracture' the data and rearrange it into categories so that comparisons can be made both within and between categories. Using Microsoft Word, the sections of text associated with particular codes were then cut, pasted and aggregated under the main themes or categories. A separate document was created for each category. The personal details of the respondents including their identity, position, organisation, roles and responsibilities, the length of their involvement in prison drug issues and their 'multiple identities' were coded and attached to the sections of texts so that the data remained contextualised and so that comparisons between the various categories of respondents could be made. A key feature of the grounded theory approach is that interpretations must include the perspectives and voices of the people, groups or organisations studied. The data were also labelled and organised temporally reflecting the separate phases of policy development. The categories and codes were also cross-referenced with the main themes generated through the documentary analysis. These links were noted both on the interview accounts and the notes relating to the various documents.

After re-examining the data under each category and exploring similarities and differences, some items were moved or reassigned to other categories, many of the categories and codes were refined and subdivided, and new codes and categories were developed. Key categories included tensions and contradictions between punishment and control and care and treatment; the role of policy networks in containing contradictions; the influence of the institutional context; the role of research and evidence; the way in which the drug problem was defined; and the impact of other policy subsystems (ie. the interface with criminal justice, penal and drugs policy), policy transfers and policy feedback. Both supporting and non-supporting data were considered in the development of analytic categories. The analysis then progressed to exploring how the various codes and categories were interrelated or linked. This process is described as 'axial coding' whereby the 'data are put back together in new ways after open coding, by making connections between categories' (Strauss and Corbin, 1990: 96). Theoretical codes were then developed which 'conceptualise how the substantive codes may relate to each other as hypotheses to be integrated into the theory' (Glaser, 1978: 72). The connections between codes and categories were then used to develop theoretical concepts and build

theories¹² relating to the role of the policy network and the various factors shaping policy during the phases of policy development. Theory generated through grounded theory is conceptually dense, but fluid, embracing the interaction of multiple actors and emphasising temporality and process (Strauss and Corbin, 1994: 279). During the process of analysis and interpretation, I searched for alternative explanations of the data by examining discrepant data and negative evidence in an attempt to falsify proposed conclusions. Grounded theories 'call for exploration of each situation to see *if* they fit, *how* they might fit, and how they *might not* fit. They demand an openness of the researcher, based on the 'forever' provisional character of every theory.' (Strauss and Corbin, 1994: 279).

The themes, categories, codes, and theories generated through this study were further refined during the process of writing the various drafts of this thesis. The processes of analysis, interpretation and writing cannot be separated (Becker, 1986; Marshall and Rossman, 1989; Richardson, 1994). Richardson (1994: 516) describes writing as 'a way of 'knowing' – a method of discovery and analysis'. The text is organised and presented using the chronology technique which follows the developmental cycle of policy development (Hammersley and Atkinson, 1983). The following four chapters correspond to the four different phases of policy development since 1980. Within each chapter, the various themes, concepts and processes are discussed and illustrated with descriptive detail.

The next section provides a reflexive account of my experiences in conducting this piece of research.

¹²For Strauss and Corbin (1994: 278), 'theory consists of plausible relationships proposed among concepts and sets of concepts.'

Reflections on interviewing busy, professional, and powerful people

Reflexivity and resistance

Almost thirty years ago, Gouldner (1970) called for a 'reflexive sociology' which argued that we must have the courage as researchers to reflect upon ourselves in the research process. The practice of critique should be directed at both the object of the enquiry (the researched) and the subject conducting the enquiry (the researcher). Gouldner (1970:489) views the historical mission of a reflexive sociology as follows: 'to *transform* the sociologist, to penetrate deeply into his/[her] daily life and work, enriching them with new sensitivities, and to raise the sociologist's self-awareness to a new historical level.' The persistence of positivism in social science is powerful. We are taught as undergraduates in sociology that researchers should remain detached and objective, avoiding the dangers of that memorable term 'going native'. Within positivism, the self is seen to distort or bias the data. As Gouldner (1970) argues, sociology has operated under the assumption of 'methodological dualism' which focuses on the differences between the researcher and those he or she observes. Here, there is the notion that research can be 'contaminated'. However, in the reflexive sociology envisaged by Gouldner, all research is contaminated and there is no possibility of sealing off the self from the generation of data. Therefore the aim of the reflexive sociologist is to recognise and understand his or her influence on the research process and in the generation of data (Gouldner, 1970: 498).

Despite the appeal of Gouldner's call for a more reflexive sociology, very few researchers publish reflexive accounts of the research process itself. There is however an emerging tradition amongst feminist researchers of providing accounts on the nature and practice of conducting research (see for example Roberts, 1981; Stanley and Wise, 1983; Scott, 1984; Gurney, 1985;1991; Finch, 1993) and also amongst anti-racist researchers, particularly in the area of education (see for example Ball, 1991; 1992; Troyna and Carrington, 1989; Neal, 1995). Such accounts have helped to highlight and politicise the debates around the conduct of research. However just as there is a paucity of research on the elite and the powerful, there are also few reflexive accounts exploring the dynamics

and issues involved in studying these groups.¹³

Even within reflexive accounts, there are bound to be some omissions and rationalisations. This is related to confidentiality and anonymity issues, but it is also linked to the problem that we as researchers may not be fully conscious to all facets of the research process or we may be unwilling to face up to some of the issues operating within the research (Hogget et al, 1994). Nevertheless, with these caveats in mind, what follows is a reflexive account of my experiences of interviewing busy, professional and powerful people in the prison drugs policy arena, exploring the relationship between myself as a researcher and the researched. As discussed above in relation to data analysis, my research diary was also used as an opportunity to record and write about my feelings, thoughts, anxieties, uncertainties and insights throughout the fieldwork period. As other scholars have argued (see Walford, 1994; Ball, 1994; Thomas, 1995; Neal, 1995; Hertz and Imber (eds), 1995), researching those in positions of power presents a unique set of problems and difficulties for the researcher.

Negotiating access

There can be difficulties in gaining access to elites. They have the power to create barriers, shield themselves from scrutiny and resist the intrusiveness of social research. There is also a perception amongst researchers that the powerful are difficult to access and thus provides an excuse to exclude them from the focus of study. As Yeager and Kram (1995: 41) argue in relation to their studies of corporate crime, 'the organizational resistance to research by outsiders is rooted in the bureaucratic 'instinct' to protect against intrusion into potentially sensitive matters and the unproductive use of valuable managerial time'. In contrast, other scholars argue that the difficulties in gaining access to elites and the powerful often have been exaggerated (see Shaffir, 1991; Walford, 1994b; Useem, 1995; Ostrander, 1995).

¹³ There are important exceptions. For example, see Neal's work on researching the powerful in higher education (Neal, 1995), the edited collection by Hertz and Imber focusing on studying elites using qualitative methods (Hertz and Imber (eds), 1995), and the edited collection by Walford which presents a series of reflexive accounts focusing on the powerful in education (Walford (ed), 1994).

Access is sometimes easier for researchers who have existing links with those in power. For example, Hirsch (1995) suggests that a researcher's 'street sense' is important. Successful research supposedly correlates with the researcher's personal knowledge and connection to the worlds about which they are writing. In these situations, access may be easier to negotiate, the researcher will have prior experience and contacts in the area, and the researcher will know what counts in these settings. In the case of my research, there is an intersection between my personal biography and research interests. Due to my background as a former researcher at the Home Office and my involvement in government funded research, I became interested in the processes of policy formulation and development and in the policy-makers themselves. In many ways, my background made negotiating access easier because I had already had experience and contacts in the area of drugs policy through previous research.

In this research, access involved multiple levels of gatekeepers including personal secretaries, other respondents, and often, security guards. Gaining access and establishing rapport was an ongoing process throughout the fieldwork. However, it was much easier than I had originally anticipated. I knew approximately one-fifth of the respondents as a consequence of other research projects I had been involved in. My approach was to telephone these individuals, explain the project, and ask them if I could interview them. In the end, their response was very favourable. Many of these contacts also provided details or introductions to other individuals they felt should be included in the study. This 'personal sponsorship' (Walford, 1994b) of the research was important in both identifying and accessing many respondents with whom I had no prior links. In some cases, there were difficulties in identifying individuals within the organisations to interview. The civil servants were particularly difficult to identify as there is no easily accessible public written record indicating which individual is responsible for each policy area. In these cases, I asked other respondents about their contacts in the various government departments. In contrast, the representatives from drug agencies, penal reform groups and professional associations were much easier to identify through annual reports and their exposure within the media.

Respondents with whom I did not have any prior links or contact details were approached with the 'cold call' (Useem, 1995). In these cases, they were sent a letter requesting their co-operation with the research (see Appendix C). Hirsch (1995) presents the idea of 'packaging' or 'customising' research by using the respondent's language in order to be accepted by them and gain entry to their world. Within the letters, I used concise and familiar language to the respondents and avoided theoretical and academic jargon. This technique was also used in the interview settings where I used their language to converse about the issues involved in prison drugs policies. As Hertz and Imber (1995: 2) argue, 'the fieldworker must be expert in at least two languages, the language of social science and the language spoken by one's respondents. The authority and success of the fieldworker are based on the ability to translate in both directions.'

Because of my status as a PhD student, I used official university headed paper which associated me with the Social Policy Research Centre. I also mentioned my supervisor's name and her role in overseeing the project, believing her proven track record in research in this area as well as the 'official' approach adopted would make the project seem more 'real', 'legitimate' and 'professional' to those who received the letter. Within these letters, I 'personalised' the research problem (Thomas, 1995) and made it clear that I was interested in *their* views and experiences to avoid being shunted off to another person within the organisation. I requested that they contact me to arrange an interview. In most cases, the respondents themselves would ring me back, but in others they had their secretaries or personal assistants make contact. When this occurred, it was not ideal. I preferred to have the opportunity to chat with the respondent before the interview and to answer any questions they might have in relation to the research. This also made meeting them for the first time less intimidating and uncomfortable for me.

Gatekeeping took a variety of forms with the civil servants. In one interview, I asked the respondent whether it would be possible to arrange an interview with his junior colleague. He suggested I would gain little from this individual as he would provide the same view and perspective. In their research on education policy, Fitz and Halpin (1994) also found this portrayal of consensus and the notion of a distinctive civil service voice

amongst the officials and politicians they interviewed. Even after access had been successfully negotiated, the differences between those working in government departments versus the voluntary sector were stark. Not only did 'research' access have to be negotiated, but 'physical' access also had to be tackled. When I arrived at government department offices, I had to pass through security clearance. This involved wearing a security pass which clearly identifies you as an outsider or visitor and in some cases, having my bag searched. Visitors are not allowed to enter the building or the corridors themselves, but must be escorted by an official. In most cases, this was the personal secretary of the respondents. At one government office building, after presenting themselves to the security guards, visitors had to enter a glass enclosed cage-like door which was then activated by security guards to allow access to the inside of the building. All of these security 'rituals' had the effect of making one feel truly like an outsider and in some cases heightened my anxiety about the interviews.

At the end of all interviews, I always asked respondents to provide names and contact details of others they thought were important for me to interview. This generated very interesting data in its own right on who knew who, who valued who and who networked with who. This technique enabled me to establish a fairly accurate picture of the membership and shape of the policy network and which members were considered to be major players. These questions also generated good advice about what sort of approach would work with their colleagues and the 'micro-politics' of the order in which they should be approached. Similar to Hunter's (1995) experience in his research on local community elites, some respondents were quite scathing about their peers and colleagues. Comments such as 'I really wouldn't bother with them, but it's up to you', 'They don't know a thing...why don't you talk to X instead', and 'Just so you don't offend X, go through Y first', were very frequent.

Elites and the powerful are particularly interested in knowing 'who else you have spoken to?' (Hunter, 1995). When I was asked this question, I tried to give vague answers because I felt that any information of this nature would be breaking my assurances of confidentiality and anonymity. But in many cases, the respondents already knew who I had interviewed and had discussed my research and its value with each other often

placing me in a very awkward and apparently foolish position. This also raises the issue as to whether research participants also have responsibilities regarding anonymity and confidentiality. The practice of 'checking out' the researcher is a common feature of research on elites (Cookson, 1994; Ostrander, 1995). As Fitz and Halpin (1994: 39) discovered, access to elites is contingent and conditional and researchers need to know how to play the game: 'one of the lessons of researching policy communities or networks is that individuals in it communicate with each other, and about you and your research. Staying in is often dependent upon not making mistakes.' During the course of my fieldwork, I became very aware that continued access depended on my 'performance' and 'conduct' in the interviews.

Knowledge

When researching elites, it is important that once access has been granted, researchers are sufficiently knowledgeable and adequately prepared for the interview (Walford, 1994; Cookson, 1994; Thomas, 1995; Useem, 1995; Gamson, 1995; Ostrander, 1995). This helps to ensure that the researcher is informed of the latest policy developments and issues, asks the right questions, gets straight answers, and avoids wasting valuable time. I carried out much preparatory work before entering the field by conducting comprehensive and detailed analyses of key policy documents, reading annual reports of drug agencies and penal reform groups and felt well-versed in the existing literature and research. I perceived the respondents as very knowledgeable about the subject, so as a researcher I wanted to tap into that knowledge in a meaningful way. A key problem was how much of my own knowledge on the subject area to disclose. Researchers can present themselves as knowledge-pursuing outsiders or knowledgeable insiders (Adler and Adler, 1987; Gamson, 1995).

The advantage of the outsider role is that it maintains clear boundaries between the researcher and the researched and enables the researcher to draw out the expertise of the respondent. On the other hand, the insider role ensures that respondents are aware that you are interested in and understand their roles. I tended to oscillate between

‘knowledgeability’ and ‘naivety’ depending on the circumstances of the interview (Ball, 1994: 99). In my case, another factor which immediately grants me outsider status on one level is my Canadian nationality. Respondents would often make reference to my accent and assumed that I was American. My nationality presented both advantages and disadvantages in the research process. It gave me a valid excuse not to know certain things and to be in a position to ask, but it also put me at disadvantage in terms of historical ‘layperson’ knowledge. By living in a country since birth, a person often picks up the nuances of historical, political, social and economic change through a process of osmosis. In some instances, respondents just assumed I would know or recall certain events and often their references to politicians, Home Secretaries, and incidents in the past would often be meaningless during interviews.

In many interviews, I felt I had to ‘show off’ my knowledge of different policies or documents, otherwise their content would have become the focus. I often felt that some respondents were patronising me. In some cases, they would ‘check out’ (Ostrander, 1995) or ‘test’ my knowledge by asking if I had read various documents and pieces of research. I would stress that I was not on a fact finding mission, but wanted to obtain their reflections on the processes and dynamics of policy development. In presenting myself solely as an ‘outsider’ in terms of knowledge, there was the real danger that they would concentrate on the facts. My aim was probe beyond a ‘public relations’ account (Walford, 1994b) or the standard ‘official’ policy line to determine the dynamics and specifics of the policy process and their personal views and experience. As Thomas (1995) admits, it is easy to be drawn in by the articulateness and charm when interviewing elites. I do feel however that I did manage to probe behind this ‘officialness’ in some interviews. For example, in three instances, I was asked by respondents to turn off the tape because they wanted to tell me something off the record, but did not want to take the chance of it being attributable. In these cases, what they told me was not earth shattering - some of it was already in the public domain – but what was significant is that they believed it was too sensitive and did not want to risk that they could be caught saying it. Similarly, during interviews, respondents would make comments and then say, ‘I do hope this isn’t attributable’ or ‘This is only for you’. They did however want to impart this knowledge or information to me.

The mode and form of interviewing varied according to the professional and work cultures and contexts of the various groups of respondents (Ball, 1994). For example, the distinctive culture of civil servants (Hennessey, 1989) presented various constraints and limitations within interviews as a result of the restrictions on disclosure discussed above. As Ball (1994: 110) argues 'civil servants are socialized to present their absence from the processes of policy-making. They are clearly often decisively influential but are almost always unwilling or unable to account for such influence.' My experience was similar in that I was often reminded by civil servants in the interviews that they were not responsible for 'making' policy and they always under-emphasised their own roles in the policy process. The discussions with civil servants tended to focus on general issues within the overall context of government policy. The data generated from these are therefore indicative of the government discourses and thinking on policy at this particular time. Rather than 'thick descriptions', these interviews tended to produce 'thin' descriptions often with important 'glimpses' or 'clues' to the dynamics and influences within the policy process (Ball, 1994). In contrast, the other categories of respondents tended to be more willing to offer their personal opinions and engage in discussions of the political dimensions and underlying value assumptions of policy-making.

Hunter (1995) argues that knowledge is the basis of the elite's power. However, my experience was that some respondents, particularly those who were relatively new players in this area of policy, exhibited insecurity about their levels of knowledge around prison drug issues. After one interview, a director of a drug agency, commented to me: 'this has just made me realise how very little I know about this subject'. Similarly, other individuals contacted for interview refused because they felt they did not have enough knowledge about the subject. Often, they referred me on to other people who they perceived to be more knowledgeable. In other cases, respondents wanted to know if what they had said to me agreed or corresponded with what others had said. Comments such as 'How does this compare with what X said?'; 'Is that the general thrust of what X thinks?'; and 'Is that what everyone else has been saying?'. When asked these questions, I endeavoured to give vague responses as I had given all respondents assurances of confidentiality and anonymity. These comments are also indicative of the concern about

‘consensus’ in this area of policy development. Their concern and insecurity may have been due to the fact that this is relatively new area of policy, it has been a politically sensitive issue and one which was neglected for many years. As a result, their experience, knowledge and willingness to share their knowledge of it may be limited. However, their insecurity and uncertainty had the effect of making me insecure and anxious about the nature of the data which was being generated. The lack of knowledge of some respondents did indicate that policy-making is far from a rational process informed through an extensive knowledge base.

The knowledge base of elites often extends into the realm of social science research itself (Walford, 1994b, Hunter, 1995). Many of those interviewed expressed knowledge of research, methodology and the research process. In many instances, this had benefits for the research and interviews. For example, respondents were amenable to being tape-recorded; in fact, they expected it. Some of them had experience of commissioning research, reading research, and in some cases, conducting research. Comments such as ‘So, you’ll be doing a semi-structured interview then?’; ‘When I was doing my MA...’; or ‘I did some research myself a few years back’ were frequent. In effect, the research process could not be mystified and my performance as a researcher was transparent. I was on display, exposed and therefore could be judged.

Authority and power

The research relationship is a power relationship between the researcher and subject (Scott, 1984; Hunter, 1995). In relation to elite studies, Ball (1994:113) urges us to recognise that the interview is an extension of the ‘play of power’ rather than divorced from it. It is simplistic to conceptualise the research relationship between elites and researchers as a one-dimensional hierarchy. Power exists on various levels and operates in different directions (Herzog, 1995; Aldridge, 1995). In some situations, respondents are more powerful while in others, the researcher has the advantage. The negotiation of status and power are an integral part of the research relationship. Several researchers who have studied elites argue that although we cannot ignore the power of elites, we

must not ignore our own power as researchers (Herzog, 1995; Hunter, 1995; Pierce, 1995). The power of the researcher can shift and change according to the different respondents, relationships and situations throughout the fieldwork. Researchers can draw on human capital such as degrees, their academic status, prestigious grants and their institution's power and prestige to create greater symmetries in the power relationship between elites and themselves (Hunter, 1995: 168). This however is not the case for PhD candidates who occupy a unique, but often vulnerable position within the academic research hierarchy. They are often isolated through working on their own, have low status, and as yet, no significant academic credentials. Their experience of research, particularly in relation to negotiation of status and power with the powerful, is often very different to that of researchers who have already gained entry to the academy or who work within a research team (Neal, 1995). Studies of elites raise questions about the researcher's identity, self-concept and status (Adler and Adler; 1990; Punch; 1986; Warren, 1988). It is important to explore the researcher's structural location in relation to respondents (Scott, 1984). The intersection of age, race, gender, academic credentials, funding and research experience help to define the researcher's status and her/his relationship to the researched.

In my case, this was the first time I had conducted an independent, non-funded piece of research. I had experience of conducting research for the National Parole Board of Canada (Duke, 1990), had worked at the Home Office Research and Planning Unit for three years (Carey-Wood et al, 1995; Duke and Marshall, 1995), and had been involved in various government funded pieces of research in my position as Research Fellow in the Social Policy Research Centre at Middlesex University (Duke, MacGregor, and Smith, 1996; Duke and MacGregor, 1997). In Maurice Punch's terms, it was the first time I was in the role of the 'lone wolf' rather than the 'hired hand' (Punch, 1994). Although this independent position was liberating and had many advantages to my previous research experience, it had many drawbacks, particularly in relation to my own authority and power. As a young woman researcher working towards my PhD with no 'official' research purpose or funders involved, I often felt vulnerable and marginal, interviewing predominantly older men in relatively powerful positions. I attempted to assert my own authority by using my title of Research Fellow at the bottom of my access letter and

drawing on my own related research experience in the interviews. I believed this presentation of my self as a bona fide researcher would lead respondents to regard my work as a serious piece of 'proper' research. On the other hand, access may have been easier for me because I was perceived to be 'harmless', non-threatening and *without* power. As Walford (1994: 224) postulates, 'female researchers may be at an advantage in being perceived as being 'harmless', especially if they are relatively young and not in senior positions with their own organisations.'

There is a need to protect the research and the researcher when interviewing those in powerful positions. In some instances, I felt deferential and was over-gracious to those I interviewed. On reflection, I could have been more confrontational and challenging in the interviews. However, I feared that 'rocking the boat' would jeopardise the interviews and gaining access to others. Ostrander (1995: 143) suggests deference and preoccupation with establishing rapport is common when interviewing elites because they are used to being in charge, asked for their ideas, and being listened to. Similarly, because some of those interviewed had been in positions of power in terms of commissioning, influencing and guiding other pieces of research I had been involved in, they may have felt they could control or influence this piece of research as well. For example, some respondents gave me suggestions as to what should be focused on in this research and how it should be designed.

It is important to feel at ease with the respondent and the setting of the interview (Davis, 1973; Gurney, 1991; Kleinman, 1991; Shaffir, 1991). The venue in which interviews are conducted can determine the level of informality or formality. In a Weberian sense, most elites occupy some sort of 'office', referring to both a physical setting and a bureaucratic position (Hunter, 1995). When interviews take place in the respondent's social space, this reinforces their position of power (Fitz and Halpin, 1994). In my experience, the few interviews which I conducted outside respondent's offices tended to be more informal. The physical set-up of the interview was also crucial. I tried to avoid 'behind-the-desk' scenarios. In most cases, I was able to conduct interviews in other parts of the office, either around a table or on comfortable chairs or sofas in the room. This helped to physically locate myself and the respondent in more 'equal' and 'neutral' positions.

Time was also a defining feature of my experience. Most of those interviewed worked within tight time frames and appeared obsessed with time. When arranging the interviews, they would ask questions such as, 'What is the time frame of the research?', 'Would next month be too late?', or 'How much time will it take?'. Because they were used to everything being urgent, some respondents would fit me into their diaries within one or two weeks of receiving the letter. In other cases however, it was made clear to me that the respondent's time was more important than mine. As Fitz and Halpin (1994:34) argue, elites have the power 'to make you wait and thus determine the pace and organisation of research'. For example, I received a phone call from one of my respondent's secretaries to arrange an interview. The first date that she suggested was not convenient to me for a valid reason. I detected her irritation and she then reminded me, 'Now dear, you must realise that you are dealing with very senior people here who have very busy diaries...'. In my access letters, I suggested that the interview would take approximately 45-60 minutes to complete. When I arrived to do the interviews, I would ask again if they had 45 minutes. In most cases, they did, but in others, they would only have 30 minutes because they were running behind schedule. This forced me to change the format of the interviews and prioritise the key questions and issues which needed to be covered. I was frequently kept waiting before interviews (one hour was not unusual), interviews were interrupted (by phone calls and secretaries), and sometimes respondents would have to leave the room to talk to their secretaries, sign documents and answer queries. During one interview, the respondent was proofing a letter he needed to sign while simultaneously replying to one of my questions. The respondents were always very apologetic about such interruptions. In some cases, however, these experiences did emphasise their marginalisation of my research and was in marked contrast to when I was working on commissioned research. This treatment did provide evidence that in some cases my research was not taken seriously or seen as important and that some respondents may have viewed granting me an interview simply as an act of altruism. In contrast to these experiences, it must also be noted that there were others who would divert their phones, ask their secretaries not to interrupt and were incredibly generous with their time.

Although I was drawn to the principles of feminist methodology and praxis which advocate a non-hierarchical and open relationship between the researcher and the researched, such protocols can often be inappropriate when researching those in powerful positions, particularly when they are mainly men (Stanley and Wise, 1983; Smart, 1984b; Neal, 1995; Hammersley, 1995). Several authors have argued that semi-structured interviews are more effective than unstructured or highly structured ones when interviewing elites as it tends to tip the balance of power in the direction of the researcher (Walford, 1994b; Thomas, 1995; Aldridge, 1995; Ostrander, 1995; Hirsch, 1995). They allow enough latitude for respondents to bring up issues that they feel are important, ensure that the researcher's main interests are covered, and can save time when it is at a premium. Very structured interviews may not work effectively with elites, because they are accustomed to being in positions of authority and leading discussions (Aldridge, 1995). In my research, I had a core set of questions or issues to cover and I made this clear at the outset of each interview. I also brought a typed topic guide to each interview which was always visible to the respondent and was prepared with pen, paper, clipboard and tape-recorder in an attempt to assert my authority over the situation. Armed with these props, I felt better able to retain control by ensuring that my agenda was covered during the interview (although I was happy for respondents to talk about other issues which they felt were important).

Elites may be prone to giving speeches and long diatribes. In my interviews, I was aware of the real danger that respondents may take over the control of the interview, thinking that whatever they said would be relevant or important to my research. In one interview, I did not have a chance to discuss the issues I needed to cover with the respondent. On several occasions, I attempted to intervene and ask particular questions to steer him back to the relevant topics, but these attempts failed. Although much of what he was saying was interesting and relevant to my research, my core set of questions/issues were not covered in any systematic or coherent way. At the end of the interview, he smiled and asked me, 'Now that was all a bit of a ramble, I hope I've covered everything you wanted me to'.

Conclusion

This reflexive account has highlighted the main features of my role and experiences in researching the powerful in the policy networks around prison drug issues and illustrates the complexity of the power relationship. Research on elites raises a particular set of issues and dilemmas which have important implications for the methodology, mode of interviewing and the processes of analyses and interpretation (Ball, 1994). Through reflexive accounts we can better understand the nature and practice of research on the powerful. However, the practice of research is increasingly becoming a privatised process (Hogget et al, 1994). When given the chance to present our research, we tend to emphasise our findings from research, rather than the methods and processes by which those results were generated. Most accounts of methodology involve a high degree of editing or sanitisation. In many cases, discussions of methodology are relegated to appendices and provide little more than a clinical summary of the technical aspects of the research. They rarely give the reader insight into the processes and the dilemmas of conducting the study. As Oakley (1981) argues, this creates the myth of a 'hygienic' research. In the current academic climate with its enduring emphasis on the research ratings determined by the Research Assessment Exercise (RAE), the race for 'quality' publications, competition for external funding and the securing of prestigious research contracts, researchers are becoming increasingly cautious and uneasy about the degree to which they 'come clean' about their experiences and the processes involved in doing research.

Chapter Three

1980-1986:

Prelude to policy development: a period of 'modest ambitions' and pragmatism

Introduction

In this chapter, I focus on the period from 1980 to 1986 which marked the beginning of external interest¹ in drug issues within the penal setting. In 1980, the Advisory Council on the Misuse of Drugs (ACMD) published its report, *Drug Dependents within the Prison System in England and Wales*. This was the first document which dealt with drug issues within the prison system. During the early 1980s, there was no public document which outlined the Prison Department's policies for dealing with drugs and drug misusers in prisons. This is in marked contrast to later phases of policy development where there was an explicit prison drugs strategy document which specified clear aims and objectives for tackling the drug problem. However, this does not mean that there was not a 'policy' on drugs during the early 1980s. As discussed in Chapter One, the absence of policy can be defined as a 'policy'. Moreover, drug misusers in the prison system were treated in a particular way and this practice can be defined as 'policy'. Policy was therefore implicit rather than explicit, unstated rather than stated, informal rather than formal, and private rather than public. During this period, there was increasing pressure from various sources for a more explicit and defined prison drugs policy. This phase could be viewed as a 'transitional' period or a 'prelude' to more formal policy development. The drugs 'problem' in both the community and the prison was changing, the type of person involved in drug misuse was changing, definitions of drug takers were changing, the location of drug misuse was changing, and the groups and professionals involved in dealing with drug misusers were changing and expanding. Furthermore, the election of the Conservative party under the leadership of Margaret Thatcher in 1979, along with the ascendancy of New Right ideas, altered the political and

¹ I am using 'external interest' to refer to interest from organisations, groups and individuals positioned outside the Prison Service or prison system.

public policy landscape dramatically.

The period prior to the 1979 election was one of crisis and chaos characterised by economic decline, high unemployment, industrial discontent, high inflation, and the decline of the manufacturing base (Evans, 1997). The election of the Thatcher government signalled the end of the post-war consensus in all areas of public policy. In particular, the key ideas, values and assumptions which underpinned the post-war welfare state and criminal justice system were questioned and blamed for the economic decline, rising crime rates, high unemployment, and the general malaise in the country. As McCarthy (1989: 4) argues, the language of social policy began to change and became based upon slogans and discourses such as 'value for money', 'deserving vs undeserving', 'self-help', 'personal freedom and responsibility', 'family values', 'genuine need', 'nil cost remits', and 'better use of existing resources'. The Thatcher government embarked on a strategy which involved radically restructuring the British economy, dismantling the welfare state, breaking the power of trade unions, reducing public expenditure and minimising state intervention.

Thatcher had placed 'law and order' issues at the centre of her election campaign and committed the government to more resources for the criminal justice system. The Conservative party focused almost exclusively on crimes which caused public anxiety such as public order and street crimes, particularly mugging (Hall et al, 1978). The existence of certain populations who were perceived to be dangerous, including black youth, 'welfare scroungers', drug addicts, and football hooligans, were used to justify and legitimise increased surveillance, regulation and punitive sentencing (Brake and Hale, 1989). In the areas of criminal justice and penal policy, the discourses of punishment and just deserts tended to prevail over those of welfare, help and treatment. Welfare agencies contracted, while penal agencies expanded (Hudson, 1993). However, the Conservative package of social and criminal justice policy reforms implemented in the early 1980s failed: crime rates continued to soar; poverty, homelessness, unemployment and ill-health increased; industrial disputes continued (notably the miners' strike in 1984), and a number of riots occurred in various inner city areas including Brixton (South London), Toxteth (Liverpool), Handsworth (Birmingham) and the Broadwater Farm Estate

(Tottenham, North London) (McCarthy, 1989; Reiner and Cross, 1991).

This macro context provides the background, framework and setting for changes within drugs, prisons and ultimately prison drugs policy during 1980-1986. I begin the chapter by exploring the drugs and penal policy contexts during the period under review. In the first section, it becomes clear that drugs policy was shaped by a heroin 'epidemic' which heightened fear and panic around drugs and drug misusers. Two contradictory discourses began to operate during this phase which were often in conflict with one another. The first discourse was 'political' which called for a more punitive or 'law and order' response to the drug problem. Paradoxically, it is important to note that prisons or drug misusing prisoners were not mentioned in this discourse. The second discourse was 'professional' which advocated a wider social approach to the problem of drugs, in contrast to the specialised medical discourse which had been prominent in the UK until the mid-1970s. In the second section, I examine the penal policy context for this period. Penal policy was constrained by the prisons 'crisis' of the late 1970s and early 1980s which was characterised by an increasing prison population, severe overcrowding, riots, industrial disputes and inadequate conditions. Moreover, the rehabilitative ideal had collapsed by the 1970s, leaving the system without a legitimising ideology. Both these policy contexts shaped the drugs 'problem' in prison and influenced the responses to it.

The second part of the chapter focuses on the drug issues in prison during the phase 1980-1986. The first section explores the nature and extent of the 'problem' of drugs in prison. The drug problem was seen to be increasing and changing as more of the prison population became involved. The response to the problem was seen to be wholly inadequate by various committees (ACMD, 1980; House of Commons Social Services Committee, 1985; 1986) and a small policy network began to emerge which lobbied for changes in the way drugs misusing prisoners were treated. It will be argued, however, that any service provision within prisons would be hindered by the reluctance of prison authorities to admit there was a problem, the collusion around drug misuse, the power of the separate health care system in prisons, the overcrowded and inadequate conditions, and the contradiction in applying treatment within a punitive, just deserts and anti-treatment framework. Recognising these constraints, the policy network adopted a

pragmatic approach and a philosophy of 'modest ambitions'. The 'problem' of drug misuse in prisons could be tackled on the outside from a release and throughcare² perspective, rather than engaging with the problem internally from within the penal arena.

Drugs policy context: the heroin epidemic and shifting political and policy landscapes

By the late 1970s, the drug dependency units established during the 1960s had become less central in the treatment of drug misuse (Stimson, 1990a). The heroin problem had stabilised and the proportion of newly notified addicts under the age of twenty-one had begun to decrease (Home Office, 1984). The clinics were treating only a small proportion of drug users, mainly heroin addicts, while the voluntary sector and general practitioners were beginning to play increasingly important roles in helping polydrug misusers, particularly those who were using barbiturates, tranquillisers, amphetamines and opiates (Jamieson et al, 1984; MacGregor and Ettorre, 1987; Glanz, 1994). In 1971, a national co-ordinating and representative body for drug services called the Standing Conference on Drug Abuse (SCODA) was established which provided a voice for the growing voluntary sector in drugs policy development. Many of the key assumptions underlying the treatment of drug misuse were being challenged in the late 1970s and early 1980s. For example, therapy and rehabilitative techniques such as therapeutic communities and counselling were becoming increasingly important; the appropriateness of maintenance prescribing was being questioned; the limitations of 'physical' treatment were recognised and a wider social approach was advocated which took into account housing, employment and training, and child care; and significantly a distinction was beginning to be made between the drug 'addict' and other patterns of drug use (MacGregor and Ettorre, 1987). Drugs experts and practitioners began to press for

² 'Throughcare' refers to the 'assistance given to offenders and their families by the Prison and Probation Services and outside agencies... [to equip them]...to fit back into society, get a job and home and cope with life without reoffending' (HM Prison Service, 1994: 5-6). For convicted prisoners this process begins at the point of sentence of imprisonment and ends when the licence is complete. For unconvicted prisoners, it begins as soon as they are received into custody.

changes in how drug addiction was defined and treated. In 1982, the ACMD published its report entitled *Treatment and Rehabilitation* which examined existing drug services and made recommendations for their development. A key recommendation was a redefinition of the 'drug addict'. The terms 'drug addict' and 'drug dependant' were to be replaced with the label 'problem drug taker' who would be defined in the following terms:

any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol or tobacco) (ACMD, 1982: 34).

This definition encapsulated a wider range of drug takers and took the view that drug problems are wide ranging, extend beyond the clinical discourses of dependence and addiction, and require more than just a medical response. The ACMD (1982) viewed the dichotomy of treatment within the clinic and rehabilitation in non-statutory agencies as unhelpful and advocated a broader social approach. Similarly, the Social Services Committee (1985: ix) argued that 'overcoming dependency demands more of a social than a clinical approach'. Thus, a more comprehensive and integrated treatment and rehabilitation policy was advocated which stressed liaison, collaboration, co-ordination and co-operation between statutory and non-statutory agencies.

The ACMD (1982) proposed that drug advisory committees (DDACs) be established in health authority districts. These new structures were to perform the following functions: monitor the extent of problem drug taking within their districts; assess the effectiveness of the existing services in meeting needs; develop and assess proposals for improvements to services; promote liaison and co-ordination between the various agencies and professions; assess the need for training and information on problem drug taking; and liaise with similar committees in neighbouring districts and with national agencies (ACMD, 1982: 40). Membership was expected to include representatives from the health service, local authority, police, probation and other statutory and non-statutory agencies.

In 1984, the ACMD further recommended that prevention and education should be included in the remit of the drug advisory committees (ACMD, 1984). It is important to

note, however, that prisons were not expected to provide representatives in these new structures.

By the 1980s, the era of the specialist in drug treatment was over and generalists in the community were encouraged to get more involved (Stimson, 1990a; Strang and Gossop, 1994). Within this new multi-disciplinary framework, new voluntary and non-specialist services in the community were established and there was a new role for the general practitioner³ in treating drug misuse. The 1982 ACMD report was influential in establishing new and broader forms of working with drug misusers around social models of care (Berridge, 1997). There was therefore a shift in balance as the prominence of the specialised medical discourse began to decline (Stimson, 1987b; Stimson and Lart, 1994).

Just as some of these new ideas and concepts began to penetrate the official world of policy-making, there was a dramatic increase in heroin misuse. In the first half of the 1980s, official indicators point to a heroin epidemic with a peak in 1985 and a subsequent levelling off in the latter half of the 1980s (Power, 1994). For example, between the years 1980 to 1986, the number of new drug addicts⁴ notified to the Home Office had increased dramatically from 1,600 in 1980 to 6,409 in 1985⁵ and then decreased to 5,325 in 1986. Moreover, the percentage of new drug addicts addicted to heroin increased by twenty per cent over this period (see Table A.3, Appendix A). The number of drug offences had also increased from 17,158 in 1980 to 23,905 in 1986 (see Table A.2, Appendix A). Although the great majority of these offences were for unlawful possession and involved cannabis, the proportion of offences associated with heroin increased from four per cent in 1980 to twelve per cent in 1985 (Home Office, 1987). Research studies conducted in various British cities and towns also indicated a sharp

³ In October 1984, guidelines on good clinical practice in the treatment of drug misuse were issued and sent by the Medical Working Group on Drug Dependence to every general practitioner and hospital doctor in the country as well as the Prison Medical Service (DHSS, 1984).

⁴ These new drug addicts tended to be younger than previous notifications. Between 1979 and 1985, the proportion of new addicts who were aged under 21 increased from thirteen per cent to twenty-four per cent. In terms of gender, the proportion of new addicts who were women remained fairly constant at approximately thirty per cent for this period (Home Office, 1987).

⁵ The rate of increase between 1980 and 1985 was approximately thirty per cent per annum as compared with only seven per cent per annum for the period 1970 to 1980 (Home Office, 1987).

increase in heroin misuse (see Ditton and Speirets, 1981; Lewis et al, 1985; Pearson, 1987a; Parker et al, 1988). The epidemic was linked to the arrival of cheap, high purity heroin in abundant supply from South-West Asia. In London, this led to a twenty-five per cent reduction in the street prices of heroin during the early 1980s (Lewis et al, 1985). Another important factor in the spread of the epidemic was that heroin from this source could be smoked⁶ which was perceived as a clean and safe way to use the drug. The stigma of injecting was therefore removed and more people were willing to experiment with the drug (Power, 1994; Griffiths et al, 1994).

The response to this 'epidemic' was to focus on heroin almost exclusively and fall back on the old ideas and discourses around disease, addiction and drug addicts. The professional consensus which had been attained around the notion of 'problem drug taking' and the need for multi-disciplinary approaches was ignored by policy-makers (MacGregor and Ettorre, 1987). The drug problem had become a highly politicised issue and the prevailing discourse was one of panic, danger and fear. Drugs had become defined as an 'alarming issue, a crisis, an epidemic, even as a plague' (MacGregor, 1989a: 3). There was much concern within political circles that the UK would 'inherit the American nightmare' where drug-taking and crime would become a way of life for the 'underclass' in society (MacGregor and Ettorre, 1987). In effect, a 'moral panic' had been created around drugs, drug misuse and drug addicts (Cohen, 1972). This was neatly characterised by a speech given by the Home Secretary, Leon Brittan, to the London Diplomatic Association in 1983 in which he professed a strategy of eradication:

Drug abuse is a disease from which no country and no section of modern society is immune...Stamping it out will be slow and painful...The rewards are great if we succeed - and the price of ultimate failure unthinkable (quoted in Home Office, 1985: 3).

The heroin epidemic was associated with a younger group of 'new heroin users' who tended to be concentrated in areas with high levels of unemployment, social deprivation (Pearson, 1987a; Parker et al, 1988) and established irregular economies for drug

⁶ Smoking heroin is also referred to as 'chasing the dragon' (see Griffiths et al, 1994: 123 for a description). Research indicates that the route of administration (ie. injecting versus smoking) varied regionally throughout Britain (Pearson, 1987a; Burr, 1987; Parker et al, 1988).

distribution (Auld et al, 1984; 1986). Heroin use was therefore not a 'national problem', but better understood as a highly localised and scattered phenomenon with patterns of use also subject to local and regional variation (Pearson and Gilman, 1994). For young people who had been deprived of achieving status through employment, heroin misuse provided a 'lifestyle' and a new mode to enhance status and prestige (Pearson, 1987b). There was however the perception amongst the public and politicians that the drug problem was spreading, spinning out of control, and corrupting other social groups. The discourse and debate in the 1980s focused on the integration of certain groups in society and fears of contamination and leakage into the general population (MacGregor, 1989a).

1985 national drugs strategy

The reaction to the drug problem in the 1980s was 'designed to preserve the existing social order.' (MacGregor, 1989a: 11). Bi-partisan agreement between Parliamentary right and left and the low level of politicisation regarding the problem led to a lack of informed political debate (Dorn and South, 1987; Berridge, 1991). Rather than leaving policy decisions to informed members of the drugs policy community, politicians and central government began to play more active roles in drug issues and policy development. In 1984, a Ministerial Group on the Misuse of Drugs was established with representatives from all government departments⁷ who had an interest in drug issues. This represented a 'new division of labour' or 'diffusion of responsibility' for drug issues between government departments (Lart, 1996: 73). The role of the group was to develop and oversee the implementation of the 1985 national drugs strategy which involved activity in five main areas: reducing supplies from abroad; tightening controls on drugs produced and prescribed; making policing more effective; strengthening deterrence; and improving prevention, treatment and rehabilitation (Home Office, 1985: 7). This marked an important shift in emphasis as enforcement measures were given much more prominence in the new strategy with three of the five aims having penal

⁷ These included the Home Office, Department of Health and Social Security (DHSS), HM Customs and Excise, Department of Education and Science (DES), Foreign and Commonwealth Office, Overseas Development Administration, Department of the Environment, Scottish Office, Welsh Office, and the Department of Health and Social Services (Northern Ireland), (Home Office, 1985, appendix A).

implications. As Stimson (1990a: 267) argues:

Whilst professional debate focused on treatment and rehabilitation, this country continued a vigorous legal and penal approach to drugs. This side of the British response has been hidden from the view of those centrally involved in policy discussions and debate. Discussions about control through legal and penal measures became prominent from 1984, and emerged from central government and Parliament rather than the caring professions. The new philosophy guiding state intervention in drugs prioritises law and order rather than medical care.

The expenditure on treatment and enforcement-related activities provides some indication of the balance between these two strands of drugs policy. For example, the total health and welfare drugs-related expenditure was estimated at £25-45 million per annum in the mid to late 1980s, compared to an estimate of £100 million for drugs-related enforcement activities (Dorn, 1990). Although the 1985 strategy stressed enforcement and the relationship between drugs and crime, the 1986-87 Drug Addiction Research Initiative⁸ uncovered very little British criminological research in these areas⁹ and recommended that future research should be conducted on drug networks at a local level, the question of effectiveness in customs and law enforcement, the relationship between drug misuse and crime, the effects of sentencing on subsequent drug misuse, alternative strategies and law enforcement, and drug misuse in prison (Berridge, 1990; Pearson, 1990).

Treatment and rehabilitation measures within the strategy centred on the Central Funding Initiative (CFI) which was developed to improve services for drug misusers. Funding over a period of three years was offered on a pump priming basis to statutory and voluntary organisations which provided new services or developed existing ones¹⁰. Most

⁸ The Drug Addiction Research Initiative (DARI) was an exploratory survey of research into illicit drugs funded by the Home Office, Department of Health and the Scottish Home and Health Department, as well as the Medical Research Council (MRC) and the Economic and Social Research Council (ESRC). See the edited collection by Virginia Berridge which includes the report of DARI and the position papers which informed its work (Berridge (ed), 1990).

⁹ By the mid-1980s, the British research base around the relationship between drug misuse and crime began to grow (see for example, Mott, 1977; 1986; Bennett and Wright, 1986; Parker and Newcombe, 1987; Hammersley and Morrison, 1987).

¹⁰ The total sum of Central Funding Initiative grants allocated was £17.5 million. These grants were

of the services which were subsequently funded by the CFI were multi-disciplinary, community-based and accessible. The initiative was successful in targeting areas which had the most serious drug problems and required drug service development (MacGregor et al, 1991). The thrust behind policy development during this period was 'to attempt to access other resources and bend them to meeting the increased need for services propelled by the increased misuse of drugs' (MacGregor, 1998a: 140). However, the moves to involve 'generalists' such as GPs, social workers, CPNs and others in the provision of services was not wholly successful and the main outcome of the initiative was a new layer of drug agencies and specialists (MacGregor, 1998a).

The developments in service provision must be located and understood within a wider policy context. Reflecting the ideas of Thatcherism, a new relationship between the state and health and social welfare emerged during the 1980s which emphasised devolving responsibility for managerial decisions to the 'periphery' or local level (Allsop, 1984) and challenged the power of medicine. The unified structure of the National Health Service (NHS) was broken down into smaller units¹¹ allowing for local diversity and a degree of local autonomy. However, at the same time, there was an increasing centralism which took the form of tighter mechanisms of financial accountability and guidelines, directives, and circulars issued from central government. Stimson and Lart (1994: 338-339) argue that these developments are mirrored in drugs policy in the 1980s with the downgrading of the medical perspective on drugs, the fragmentation and local diversity in service provision and the increased centralism of the new Ministerial Group on drugs, the national drugs strategy and the more active state role in drug issues. Drugs policy was thus shaped by these new relations between the state and medical and social services which allowed for both strong central influence and an emphasis on local expertise and decision-making (Stimson and Lart, 1994).

Prevention activities under the government's new strategy were in the form of high

followed by allocations from central government to Regional Health Authorities based on number of those aged 15 to 34 in their populations (MacGregor, 1994: 259).

¹¹ For example, the Area Health Authority tier of management was abolished and District Health Authorities (DHAs) were created. As a result of the Griffiths' Management Inquiry, each District was to determine its own structure and pattern of units and management.

profile mass media anti-heroin campaigns beginning in 1985¹². These initiatives were viewed with suspicion by the drugs policy community which warned the government against a national campaign based on fear tactics as this could backfire by stimulating interest in drugs and leading to increased experimentation (ACMD, 1984). As Power (1989) has argued, even a perfunctory review of the literature on campaigns confirms such views and reservations. Research demonstrating the lack of success of media campaigns based on fear arousal has a long history dating back to the 1970s (see Capalaces and Starr, 1973; Goldstein, 1974; Atkin, 1979). Despite the warnings, the government went ahead with their plans. Both quantitative and qualitative evaluations of the campaigns were undertaken and confirmed that young people's attitudes against heroin had been reinforced (Research Bureau Ltd, 1986; Andrew Irving Associates, 1986). However, these evaluations have been criticised on methodological grounds due to the sampling design and size (see Marsh, 1986). Moreover, as Dorn (1986) argues, the researcher's conclusions were based on the incorrect assumption that strong anti-drug attitudes will prevent drug use or that a change in attitude will produce a change in behaviour.

Enforcement efforts took the form of new structures of drug enforcement, penalties, surveillance and intelligence. Drug traffickers and dealers were the targets of these efforts and the aim was to ensure that they were 'punished severely and should not profit from their illegal activities' (Home Office, 1985: 14). The National Drugs Intelligence Unit (NDIU) was created under the command of a newly established post of National Drugs Intelligence Officer and regional crime squad drug wings were established to bring a greater degree of co-ordination into the policing of drugs. Following the recommendations of the 1985 Home Affairs Committee, the Drug Trafficking Offences Act of 1986 introduced wide powers for the confiscation of assets of drug dealers. The 1985 Controlled Drugs (Penalties) Act increased the sentencing tariff for trafficking in Class A drugs from 14 years to life imprisonment. Greater attention was also paid to international co-operation with regard to drug trafficking through the ratification by the

¹² In 1985, the government launched the 'Heroin Screws You Up' campaign which focused on the adverse health consequences of drug misuse. In 1987, a further campaign was launched, 'Smack Isn't Worth It', which focused on social consequences and constructed the use of heroin as a direct threat to the family.

UK of the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 and by a series of bilateral Mutual Legal Assistance Treaties agreed between the UK and a number of countries. The assumption was that activity on the supply front and the disruption of low level markets would impact upon the demand for drugs by reducing availability and making them more expensive (Dorn and Murji, 1992).

As South (1998: 91) argues, these developments 'placed the police, customs, courts and prisons at the forefront of official rhetoric about responses in policy and practice'. These punitive measures were aimed at the traffickers or the 'corruptors' of drugs, rather than the drug users or the 'corrupted' (Young, 1973). In practice however, Pearson (1991) argues that these enforcement activities coexisted along with harm and demand reduction strategies. Although abstinence was being stressed at the political level, the ACMD (1984) was advocating risk reduction and harm minimisation as the two basic criteria for drugs prevention. There was therefore a clear gap between the 'political' and 'policy community' views of drugs (Berridge, 1991). Similar to previous phases of drugs policy development, a bifurcated policy of control was pursued which now involved life sentences and confiscation of assets for drugs traffickers and improved services, diversion and prevention initiatives for users and potential users (Dorn, 1990). However, enforcement type activity has much more political and populist appeal compared with health-based initiatives which can appear 'too soft'. Politicians and policy-makers were therefore able to stress that tough action was being taken against drug traffickers and other drug 'villains', while drug workers and other professionals were working behind the scenes dealing with 'problem drug takers' or drug 'victims' within a treatment and rehabilitation based framework.

Although medicine remained a central force in drugs policy-making, Berridge (1997) argues that the medical hegemony of drugs policy was becoming diluted. During the 1980s, the policy community around drugs broadened to include a wider professional spectrum as new alliances were developed (Edwards, 1990). For example, the ACMD membership began to change from a mainly medical one, to one which included social workers, teachers, police and probation officers, psychologists, sociologists as well as

the traditional psychiatrists and pharmacologists (Edwards, 1990; Berridge, 1991; 1997).

Although the 1985 drug strategy was generally viewed as a penal response to the drug problem, the irony was that there was no reference to the Prison Service, the treatment needs of drug misusing prisoners or to the ACMD report on drug dependants in the prison system published in 1980. Within the prison environment, much of the new thinking regarding drugs and drug treatment failed to penetrate policy and practice immediately. Indeed, for many years, what was occurring outside the prison walls had not impacted on how prisoners with drug problems were treated. There were different discourses around drug issues operating inside and outside the prison walls. The next section will outline the context and main developments within penal policy during the period 1980-1986.

Penal policy context: containing and managing the 'crisis'

By the 1970s, the penal system was described by a number of commentators from various perspectives as being in a 'state of crisis' (see Evans, 1980; Hall, 1980; Bottoms, 1980; Fitzgerald and Sim, 1982; Woolf, 1991). The penal crisis is best understood as an interaction of material and ideological factors (Cavadino and Dignan, 1997). For example, Fitzgerald and Sim (1982) argue that there is not a single prison crisis, but a series of interwoven crises: the crises of 'visibility', 'authority', 'containment', 'conditions', and 'legitimacy'. The key explanatory factor is the 'crisis of legitimacy' or engaging with the question 'what are our prisons for?'. Since the collapse of the rehabilitative ideal in the early 1970s, which placed emphasis on the treatment, training and reform of offenders (Allen, 1981), policy-makers and politicians have not engaged effectively with this 'crisis of legitimacy'. Instead, they have tinkered with sentencing and parole policy, hoping to have an impact on prison numbers and, when given the choice, they have placed security concerns at the centre of the policy agenda. With the election of the Thatcher government, the rhetoric of 'law and order', 'just deserts' and 'punishment' emerged as the legitimising ideologies of penal and criminal justice policy (Hall, 1980).

In Britain, the emphasis on treatment, training and rehabilitation began to shift following the 'crisis of containment' in the 1960s (Fitzgerald and Sim, 1982). During this period, there was a significant increase in prison escapes, including a number of high profile criminals¹³, which prompted the government to call for an inquiry. Lord Mountbatten was asked to examine the reasons for the escapes and make recommendations for improved security. His main conclusion was that high risk prisoners were being held in insufficiently secure accommodation while low risk prisoners were subjected to overly secure regimes (Home Office, 1966). A security-based classification scheme was recommended in which the most dangerous prisoners would be classified as category A and subject to the most stringent security measures, those in categories B and C to medium security levels, and those in category D would serve their sentence in relatively open conditions. This classification scheme was adopted and has endured to the present day. Mountbatten also recommended a 'concentration policy' whereby category A prisoners would serve their sentences in a new purpose built top security prison on the Isle of Wight – the 'Vectis'. However, the Advisory Council on the Penal System (1968) rejected the idea of concentration on the basis that it would be difficult to provide an adequate regime for a small number of prisoners and that disruptive prisoners would have no place to be transferred. As a result, a policy of 'dispersal' was adopted which involved dispersing category A prisoners throughout a limited number of training prisons with upgraded security. The Mountbatten report left an important legacy on the prison system and introduced a new era characterised by an intensification and proliferation of security, surveillance and control across the entire prison estate (Sim 1991; Downes and Morgan, 1997).

By the late 1970s, the prison population had increased dramatically from an average population of 37,820 in 1975 to 42,264 in 1980 (see Table B.1, Appendix B). This increase led to severe overcrowding with two and three prisoners being held in a cell built for one, degrading conditions and inadequate sanitation (Fitzgerald and Sim, 1982).

¹³ These included Charles Wilson and Ronald Biggs who were serving thirty year sentences for their part in the Great Train Robbery of 1963 and the spy, George Blake, who was serving a forty-two year sentence for espionage.

The 1970s were also characterised by concerns about security, control and containment. For example, the prisoners' rights movement began in 1972 through the National Prisoners Movement (PROP), a series of serious riots¹⁴ took place, and prison officers engaged in an increasingly militant campaign of industrial action over pay and conditions. As Fitzgerald and Sim (1982: 2) note 'what everyone did agree about was that at the end of 1978 the prison system was in crisis'.

In November 1978, the government responded by establishing a committee under the leadership of Mr Justice May to inquire into the state of the prison service. The May Committee recommended a massive prison building and refurbishment programme to end the practices of slopping out and sharing cells. They also made recommendations in relation to the objectives of the penal system conceding that the 'rhetoric of 'treatment and training' had had its day and should be replaced' (Home Office, 1979: para. 4.27). Roy King and Rod Morgan, in evidence to the Committee, argued that a policy of 'humane containment' should be adopted which would be underpinned by three important principles: minimum use of custody; minimum use of security; and the 'normalisation' of the prison. The May Committee rejected 'humane containment' claiming it was a 'means without an end' and would result in prisons becoming human warehouses for prisoners and staff (Home Office, 1979: para. 4.24). They put forward the concept of 'positive custody'¹⁵ with the hope of developing regimes with a real purpose and objectives. King and Morgan (1980) rightly condemned 'positive custody' as vague and meaningless. However, the implementation of the May Report became the responsibility of the new Thatcher government and the notion of 'positive custody' was never officially adopted.

Morris (1989: 189) argues that the Thatcher government would never have considered

¹⁴ There were major riots at Brixton in 1972, Hull in 1976, Gartree in 1978, Wormwood Scrubs in 1979 and Albany in 1983.

¹⁵ The statement defining 'positive custody' was as follows: The purpose of detention of convicted prisoners shall be to keep them in custody which is both secure and yet positive, and to that end the behaviour of all the responsible authorities and staff towards them shall be such as to: a) create an environment which can assist them to respond and contribute to society as positively as possible; b) preserve and promote their self respect; c) minimise, to the degree of security necessary in each particular case, the harmful effects of the removal from normal life; d) prepare them for and assist them on discharge. (Home Office, 1979: para 4.26).

setting up a structure like the May Committee, preferring instead to employ 'high powered individuals from the world of commerce to conduct managerial-style reviews'. During the 1980s, Royal Commissions and standing advisory bodies¹⁶ tended to be replaced with official inquiries which were ad hoc, highly specific, short-term, manageable, and internal (Downes and Morgan, 1997). By the 1980s, links between the Home Office and pressure groups were strengthened forming a policy community which interacted over various issues. Although the government often ignored protest from the pressure groups, it also recognised their use in identifying problems, assessing the feasibility of reforms and increasing the legitimacy of the policy process (Downes and Morgan, 1997: 115). New pressure groups¹⁷ emerged on the scene including Inquest which was founded in 1981, the Prison Reform Trust in 1982 and Women in Prison (WIP) in 1983. During the 1980s, the penal reform lobby and academic commentators began to press for the recognition of prisoners' rights and timetables for the introduction of minimum standards and conditions (Morgan, 1997) while the new government began devising strategies for 'managing' the prison system.

The problems of an increasing population, overcrowding, riots, and industrial action by prison officers endured throughout the 1980s. The response by the Conservative government was one of 'penal pragmatism' with no consideration of long-term or overarching goals (Bottoms, 1980: 4) and a contradictory mix of policies. In 1982, the most extensive prison building programme since the nineteenth century was initiated. While the prisons were being built, two techniques were employed to reduce the prison population and overcrowding which simultaneously appeased both the 'law and order' lobby and liberal critics. These included increasing the numbers of short-term offenders eligible for parole and introducing a range of community penalties to divert offenders

¹⁶ For example, the Advisory Council on the Penal System which had provided much criminological expertise to the government was abolished in 1980.

¹⁷ Many pressure groups in the area of penal reform have long histories. For example, the Howard League for Penal Reform was founded in 1921 through an amalgamation of the Howard Association founded in 1866 and the Penal Reform League formed in 1907 (see Ryan, 1978 for an historical analysis of the 'partnership' between the Howard League, Home Secretary and civil servants). During the 1960s and 1970s, there was a proliferation of pressure groups including the Apex Trust in 1965, National Association for the Care and Resettlement of Offenders (NACRO) in 1966, Radical Alternatives to Prison (RAP) in 1969, Legal Action Group (LAG) in 1971, Society for Voluntary Associates (SOVA) in 1975, and Labour Campaign for Criminal Justice in 1978 (see Ryan, 1983 and Ryan and Ward, 1992 for an analysis of the different ideologies, commitments and perspectives of the groups).

from custody, while simultaneously increasing parole restrictions for those who had committed more serious and violent offences. Both techniques were part of a bifurcated policy or twin-track approach which distinguished the most serious and dangerous offenders from the less serious and dangerous, ensuring the former received tough prison sentences with restricted prospects for parole and the latter received more lenient measures in the community (Bottoms, 1977; 1980). Such a strategy had great political appeal because it allowed the government to remain tough to the law and order lobby and populist opinion, whilst simultaneously appearing soft to liberal critics (Edelman, 1984).

In 1984, the Home Secretary, Leon Brittan, reduced the minimum qualifying period for parole from twelve to six months. This led to an increase in the numbers of grants of parole to short-term prisoners who had committed less serious offences. At the same time, parole restrictions were imposed on those who had committed more violent and serious offences. For example, prisoners serving life sentences for certain types of murder¹⁸ would normally remain in prison for a minimum of twenty years before becoming eligible for parole, unless there were exceptional circumstances. Similarly, prisoners serving more than five years for violent offences or drug trafficking were unlikely to be granted parole until just before the ends of their sentences or in exceptional circumstances. The parole policy had two main effects. Firstly, it led to a dramatic increase in the long-term prison population. Secondly, it removed all incentives amongst long-term prisoners towards positive behaviour and led to much hostility and unrest (Cavadino and Dignan, 1997).

The loss of faith in rehabilitation as the primary purpose of imprisonment and the rising prison population also led to a proliferation of 'alternatives to custody' which reflected a growing disillusionment with the efficacy of prison for reforming offenders and the costs of mass imprisonment. In the early 1980s, such alternatives included community service orders and intermediate treatment for juvenile offenders. The new alternatives to

¹⁸These included the murder of a police officer, sexual or sadistic murder of a child, terrorist murder, or a murder using firearms during the course of a robbery (NACRO, 1989).

custody were thought to be both more humane and effective. However, the criticism of deinstitutionalisation that developed in the 1970s and continued in the 1980s suggested that these forms of punishment were not more humane or effective in terms of cost or reducing offending than imprisonment (Greenberg, 1975). In fact, it was argued that these forms of decarceration actually widened the net of social control and extended the segregative principle from the institution to the community (Cohen, 1977, 1985; Hudson, 1984). The mode of penalty had been dispersed throughout society to more locations, agencies and personnel. Throughout this era, the prison persisted and community corrections supplemented, augmented, and replicated the prison rather than replacing it.

By the mid-1980s, the institutional context of policy-making began to shift as increasing emphasis was placed on the financial management¹⁹ of the public sector and drives toward the 3 E's: Economy, Effectiveness and Efficiency. Managerialism began to creep into all areas of public policy and the problems of crime and punishment were no exception. This was particularly evident in a statement of tasks for the Prison Service set out in 1984 by the Director General:

The task of the Prison Service is to use with maximum efficiency the resources of staff, money, building and plant made available to it by Parliament in order to fulfil, in accordance with the relevant provisions of the law, the following functions:

- i) to keep in custody untried or unsentenced prisoners and to present them to court for trial and sentence;
- ii) to keep in custody, with such degree of security as is appropriate, having regard to the nature of the individual prisoner and his offence, sentenced prisoners for the duration of their sentence or for such shorter time as the Secretary of State may determine in cases where he has discretion;
- iii) to provide for prisoners as full a life as is consistent with the facts of custody, in particular making available the physical necessities of life; care for physical and mental health; advice and help with personal problems; work, education, training, physical exercise and recreation; and opportunity to practise their religion;
- iv) to enable prisoners to retain links with the community and, where possible, assist them to prepare for their return to it. (Prisons Board Statement on the Tasks of the Prison Service, December 1984, Home Office Circular Instruction 55/84).

¹⁹ Under the FMI (Financial Management Initiative), all services in the public sector were required to provide a statement of objectives and a means for measuring performance. Control of resources in relation to these objectives was devolved to managers of these services (Prime Minister, 1982).

As Morgan (1997: 1148) argues, the statement focused on the technical and legal requirements of the Prison Service, provided no rights or standards for prisoners and did not engage with the question of legitimacy or 'what are prisons for'. However, it did have the potential to draw attention to and highlight the lack of service provision within prisons.

The penal strategies of the early 1980s cannot be deemed successful in their practical aims. The prison population continued to rise, overcrowding was still a problem, inadequate conditions prevailed and riots and disturbances were regular occurrences. During the period 1980 to 1986, the average prison population rose from 42,264 in 1980 to 46,770 in 1986 (see Table B.1, Appendix B). The crisis of legitimacy remained untackled with no long-term strategy, penal philosophy or overarching goals identified for the prison system. It was within this penal setting and policy context that the issue of drug misusers in the prison system began to be debated.

Nature and extent of the 'problem' of drugs in prison

It was not until the late 1970s that the issue of drug misusers within the prison system began to be recognised and debated. Historically, drug misusers in the criminal justice system, and particularly prisoners, had not been given prominence in discussions of drugs policy. As one commentator argued, 'in the 1970s prisons were regarded as a footnote, albeit a perplexing one, in the treatment and rehabilitation debate' (Runciman, 1996: 4). Similarly, the problem of drugs misusing prisoners had not been a priority within penal policy. At this time, there was virtually no research or evidence on the extent or nature of the drug problem in prisons and very little external scrutiny (Berridge, 1990; Pearson, 1990). Although there was no official, formal documented policy or strategy which was publicly accessible, drugs misusing prisoners were dealt with by the Prison Medical Service (PMS). There was growing criticism of the practices of the PMS from drugs experts and other professionals in the community. The interest in the issue therefore emanated from external sources, rather than from internal sources within the prison

system. In the 1980s, three investigations were conducted which began to examine the treatment of drug misusers in prison, highlight and define the problem, and question existing strategies. These included the 1980 ACMD report on drug dependants within the prison system, the 1985 House of Commons Social Services Committee Report on the Misuse of Hard Drugs, and the 1986 House of Commons Social Services Committee Report on the Prison Medical Service.

By the late 1970s, the drugs policy community began to show interest in the drug issue in prisons. For example, in June 1977, the ACMD working group on Treatment and Rehabilitation appointed three of its members²⁰ to examine and report on the treatment of drug dependants²¹ within the prison system. Their work was completed two years later in the summer of 1979, submitted to the Home Secretary on 16 December 1979 and published in 1980. Statistical evidence collated by the enquiry indicated a growing number of drug dependants entering the prison system. A sample of male addicts, followed up for five years after their first notification, showed over half (56%) had some experience of custody (Mott, 1977). The report also provided evidence that the majority of prisoners who were considered to be addicts had not been receiving treatment during the year in which they were imprisoned.

Prior to the 1970s, prisoners with drug addiction problems tended to be viewed by both prisoners and prison staff as particularly 'deviant' and on the margins of the mainstream criminal population and culture within prisons. Many drug addicted prisoners were forced to keep their addiction hidden to avoid mistreatment, bullying and harassment from other prisoners and prison staff. Very few would actively seek treatment and help.

²⁰ This group included Mrs J Hart, Mrs R Runciman, and Dr D Wild. From January 1978, Mrs Hart's place was taken by Mr D Turner. Visits were made to seven prisons including Brixton, Pentonville, Holloway, Wormwood Scrubs, Grendon, Winchester and Feltham. Discussions were held with representatives of the Prison Medical Service, NACRO, the Parole Board, Probation, and the Institute of Criminology, Cambridge (ACMD, 1980).

²¹ In the ACMD report and in accordance with Prison Department practice at that time, the term 'drug dependant' refers to all those who are 'received into custody, including those remanded in custody before trial or sentence, who, in the opinion of a prison medical officer, are dependant upon drugs (excluding alcohol) whether or not the drugs are controlled by the Misuse of Drugs Act 1971 or are drugs controlled by that Act to which Notification of Addicts Regulations apply.' (ACMD, 1980, footnote 1, p. 1).

During the late 1970s and early 1980s, there was a perceived shift in the prison population in relation to the characteristics of drug misusers or drug involved offenders. A director of a drug agency who had been involved in drug treatment in prisons during this period suggested there was a shift or crossover emerging between mainstream criminality and drug importation and dealing:

People who were coming in with drug problems were considered second class citizens for a long time and were almost in the same category as child molesters. They were seen apart from the criminal population and they didn't really mix very much...It used to be the case in the 1970s that criminal gangs down in South London wouldn't touch drugs. It was mainly the hippies, degenerates and down and outs. Then what started to happen is that mainstream criminals started to get into drug importation. The whole division started to get more blurred.²²

Mirroring what was occurring in the community during the period 1980-1986, increases in drug misuse and drug offences were also represented in the prison population in terms of official indicators. For example, the number of new drug addicts notified to the Home Office by prison medical officers increased from 320 in 1981 to 1,102 in 1986 with the proportion of all notifications increasing from fourteen per cent to twenty-one per cent during this period (see Table A.1, Appendix A). In addition, drug offenders sentenced to custody had increased in number from 1,676 in 1980 to 3,928 in 1986, with the proportion rising from ten per cent to sixteen per cent over this period (see Table A.2, Appendix A).

Illegal and legal drugs: issues of control and collusion

During the late 1970s and early 1980s, there was increasing concern that prescription drugs, such as tranquillisers, were being used as mechanisms of control and discipline by the Prison Medical Service, particularly in women's prisons (Fitzgerald and Sim, 1982; Ryan, 1983; House of Commons Social Services Committee, 1985 and 1986; Sim 1990).

²²Interview (003) with director of drug agency, October 1997.

In November 1977, the Medical Committee Against the Abuse of Prisoners by Drugging was formed through the National Prisoner's Movement. It consisted of representatives from the National Prisoners' Movement, the National Council for Civil Liberties, the National Association for Mental Health, SCODA, Radical Alternatives to Prison and Release, as well as a number of consultant psychiatrists. The Committee monitored the allegations of drugging and campaigned for a prison health service administered by the NHS (Sim, 1990). By 1986, contradictory evidence was submitted to the Social Services Committee regarding the levels of prescribing. Some submissions pointed to excessive levels and coercive practices, while other evidence indicated that prescribing policy had undergone a radical change with prisoners being subjected to abrupt and inhumane withdrawal (House of Commons Social Services Committee, 1986: xli-xlii).

The use of prescription drugs in controlling prisoners links to the collusion amongst prison staff around the use of illegal drugs. Evidence submitted to the 1985 Social Services Committee suggested that illegal drugs were available and being used in the prison system. For example, the Association of Police Surgeons reported:

When the addict goes to prison he will be able to, in most circumstances, continue with drug abuse. While we appreciate the difficulties for the prison authorities with the present state of overcrowding especially in local prisons, it is common knowledge among addicts that drugs are available (House of Commons Social Services Committee, 1985: xxxiii).

Similarly, the Prison Medical Association argued it was, '...difficult to initiate treatment and rehabilitation in long-term prisons where uncontrolled drink and drugs are so readily available.' (House of Commons Social Services Committee, 1985: xxxiv). There was also evidence, albeit limited, of the availability of drugs within prisons in the annual reports of the Prison Service. For example, since the 1970s, deaths associated with drug overdoses and misuse had been recorded²³ and dogs were increasingly being trained to

²³ These include a remand prisoner who died in coma after swallowing a large amount of illicitly obtained LSD in 1974 (Home Office, 1975), an inmate who died of serum hepatitis as a result of the self-administration of drugs in 1976 (Home Office, 1977), an inmate who died of self-administration of drugs in 1977 (Home Office, 1978) and two inmates who died following drugs overdoses in 1982 (Home Office, 1983).

detect drugs²⁴.

Despite these rumours and evidence, the Prison Service was reluctant to publicly acknowledge an 'illegal' drug *problem* in prisons. This collusion was a powerful force which masked the nature and extent of the problem and also had a detrimental effect on initiating research in this area. In a summary of research on drugs, law enforcement and criminology in 1986, Pearson (1990:142) described the problems of negotiating access on drug issues in prison as 'insurmountable'. A public admission or evidence on the nature and extent of the problem might have forced the prison authorities to initiate some form of action to deal with it. Such a tacit admission would have indicated the failure or non-existence of a drugs policy. Drugs, particularly cannabis, were viewed as functional in that they kept the prison and prisoners quiet and under control, making the job of prison staff easier. As the National Association of Probation Officers (NAPO) argued in their evidence to the 1985 Social Services Committee, 'uniformed prison staff collude with the use of cannabis unless it becomes so virulent that a 'purge' is necessary for credibility to be retained' (House of Commons Social Services Committee, 1985: 48). Those who had been involved in prison drug treatment during this period suggested that the collusion and complacency around drugs use was related to control issues:

*What you had was a Prison Service - a monolithic organisation- which had a stance that if we don't talk about it, we don't have to do anything about it.*²⁵

What appeared to be occurring was a form of 'institutionalised' collusion:

*There was a complacent attitude - a collusive attitude - by prison personnel. Because with a compliant, stoned population, they were much easier to manage. It was an institutionalised collusion....It was a lot of turning a blind eye.*²⁶

²⁴ In the 1984 annual report of the prison department it was reported that 'a substantial number of specialist drug searches were undertaken, around two-thirds of which led to the discovery of varying quantities of drugs. The complement of dogs trained to detect drugs rose from 28 to 40' (Home Office, 1985b: 43).

²⁵ Interview (010) with director of drug agency, November 1997.

²⁶ Interview (015) with director of drug agency, November 1997.

Thus, both illegal and prescribed drugs were used as mechanisms of control within a prison system which was operating in a context of an increasing population, overcrowding, inadequate conditions and unrest. Illegal drugs were condoned and legal drugs were prescribed to minimise disruption and to contain and manage a potentially volatile population which was increasingly made up of prisoners serving long-term sentences with little hope of parole. This collusion prevented the growing illegal drug problem from becoming public and therefore policy in this area was private, in-house and internal. As Heclo (1972) reminds us, policies can consist of what is not being done.

Dealing with drug misusers in prisons

Paradoxically, it was within the non-treatment, non-rehabilitative and 'just deserts' penal framework which had emerged during the late 1970s and early 1980s and the collusive environment around drugs, that the ACMD (1980: 1) rather naively suggested that a prison sentence should be regarded as an 'opportunity' for drug treatment and rehabilitation:

A prison sentence...presents an important opportunity to offer treatment and rehabilitation to drug dependants, and the prison service has an importance for any consideration of treatment and rehabilitation out of all proportion to the numbers of drug dependants found there at any one time.

In 1985, this point was reiterated in the Social Services Committee report (1985: xxxiii) on the misuse of hard drugs: 'our greatest concern is that the time so many addicts spend in custody represents a wasted opportunity for tackling the problem of their addiction'.

The role of the Prison Medical Service

During the period 1980-1986, the Prison Service had its own system of health care, the Prison Medical Service (PMS)²⁷, which is separate from the National Health Service

²⁷ Under the Prison Act 1952, every prison is required to have a medical officer.

(NHS). Prison doctors and medical staff are employed by the Prison Service and are not accountable to health authorities in the outside community. Medical staff within prisons have always experienced an acute conflict between their contradictory roles of caring for the health of prisoners and maintaining control and discipline (Sim, 1990; Ralli, 1994). For example, under the Prison Rules²⁸, medical officers have the dual responsibility of providing medical care and ensuring that prisoners are fit for certain punishments, such as solitary confinement and physical restraints. Sim (1990: x) cogently argues that control and discipline have been more central to their roles than health care: 'prison medical workers, rather than operating from a perspective bereft of ideology and politics, have been intimately involved in reinforcing the discipline of penalty'. Similarly, in evidence to the 1986 Social Services Committee enquiry into the Prison Medical Service, the Royal College of Psychiatrists urged a review of the prison medical officer's role:

The Home Office should recognize that both administering a system of punishment and at the same time procuring the health of those being punished are incompatible objectives...Historically, the prison medical officer's role has developed into that of a referee who could be relied on to support the home team. The prison doctor's role outside the provision of health care needs reviewing (House of Commons Social Services Committee, 1986: 62).

The Prison Medical Service was central to how drug misusers were dealt with in the prison system during the 1980s. Drug addiction was defined by the Prison Service primarily as a medical problem and dealt with internally. Drug treatment, particularly withdrawal programmes, were firmly located in the hands of Prison Medical Officers and subject to their clinical judgement. Drugs policy was therefore related to the internal practices of prison medical officers. All prisoners, both those beginning their sentences and on remand, were medically examined by a prison medical officer on admission to prison, providing the main opportunity to identify drug misusers. The initial assessments, however, were noted to be very brief and often 'perfunctory to the point of uselessness' (House of Commons Social Services Committee, 1986: xi.). This was mainly due to the large numbers of new prisoners who had to be processed in a very limited period of time, as well as the prison medical officers' lack of experience and training in working with

²⁸ Prison Rules 1964 as replaced by Prison Rules 1999.

drug misusers (ACMD, 1988). As a result, many drug misusers escaped detection and some actively tried to conceal their drug misuse due to fear of being sent to a more secure prison, increased chance of cell searches, and a reduced chance of early release (Tippell, 1989). Women prisoners, in particular, are often reluctant to disclose a drug problem, as they fear their children may be taken into care (Nichols and Henderson, 1990). If prisoners were identified as drug misusers on reception, they could be offered a short-term withdrawal programme depending on the professional judgement of the prison medical officer.

Historically, the discourse of less-eligibility has underpinned penal policy whereby prisoners should not be seen to be in receipt of services or living in conditions which are superior to those living in the community (Sim, 1990; Sparks, 1996). When this discourse is translated into penal practice however, it has often meant that prisoners receive a standard of service provision well below that offered in the community. The discourse of less eligibility also applies to the treatment prisoners receive for drug addiction and has a long history. For example, the Rolleston report of 1926 defined addiction as a disease requiring medical treatment and legitimised maintenance prescribing. However, the approach derived from the Rolleston report was class-based and had been developed for the middle class addict who was perceived to be 'deserving' and 'respectable' (Berridge, 1989; 1999; Stimson and Lart, 1994). In contrast, the Rolleston consensus was not extended to drug addicted prisoners who were treated by methods of abrupt withdrawal. Berridge's analysis (1999: 274) illustrates how, 'the prison doctors formed a distinct group who always favoured harsher methods, in particular the abrupt withdrawal method of treatment; their addict clientele was distinctively different'.

These distinctions between treatment in the community and prison have continued. For example, the ACMD (1980) argued that treatment in prisons was not congruent to what was being offered in the community and that much of the existing provision was inadequate and dated. Treatment provision in prisons had not kept pace with the new thinking and theories around addiction:

In theory treatment is offered to whoever wants it for the personality disorders of which, in the view of the Prison Service, drug dependence is only one symptom. We would suggest that there is a need to consider other models and theories of addiction, in line with the changes which are occurring within the therapeutic communities (ACMD, 1980: 4).

The professional consensus which had been achieved in the community around ‘problem drug taking’, social models of care, and integrated treatment and rehabilitation had not penetrated the prison environment. Within the penal setting, the dichotomy between medical treatment and rehabilitation persisted. The Social Services Committee (1986: xxxix) argued that drug addiction in prisons should be defined as a social service problem, rather than a medical problem.

The ACMD (1980) also criticised the withdrawal programmes in prisons as inadequate, particularly in relation to remand prisoners. Three recommendations were made to improve withdrawal procedures emphasising that they should take full advantage of the techniques developed by specialised units in the NHS; maintenance regimes should be instituted for drug dependant remand prisoners; and the widest possible use should be made by the courts of drug treatment centres, for remanding notified drug dependants on bail for the purpose of obtaining medical reports (ACMD, 1980). However, it was clear the legacy of the practices adopted by the prison doctors of the Rolleston era had endured. In their response to the ACMD report, the Home Office advocated an abstinence-only approach and considered maintenance regimes inappropriate within the prison system (Home Office, 1980). Five years later, in the 1985 Social Services Committee report, submissions indicated that withdrawal programmes in prisons remained inadequate. Although provision varied between establishments, many prisoners taken into custody in police cells, remand centres and prisons were only given one option – abrupt withdrawal. In evidence to the Committee, Dr Akhter of the Royal College of Psychiatrists provided this graphic description of the inhumane treatment drug addicted prisoners received: ‘the only treatment that drug addicts get in prison is ‘cold turkey’. Nothing is prescribed and they are just given a mattress on the floor’(House of Commons Social Services Committee, 1985: xxxiii).

There were clear contradictions between the public and private discourses operating within the prison system. The public discourse was pushing forward the punitive, anti-drug, abstinence-based approach, while the private discourse was quietly condoning and permitting drug misuse. The private discourse involved turning a 'blind eye' and collusion to maintain control of an increasingly unstable system.

Drug treatment provision

In the majority of prisons during the 1980s, drug treatment and counselling programmes were scarce (ACMD, 1980; Social Services Committee, 1985; 1986). The Social Services Committee (1985: xxxv) concluded: 'we cannot but condemn the absence of even rudimentary services for prisoners with a history of drug misuse, both while in custody and after release'. Despite the growth and diversity in services in the community, there were very few outside agencies undertaking drug work in prisons (Hamer, 1998). Most provision was internal, medically driven and provided on an ad hoc and individual basis. A civil servant suggested that the lack of service provision was related to the failure to acknowledge the problem of drug misusers within the prison system and the lack of a clear drugs policy at this time:

...Prior to the 1990s, there was very little clear action on drugs in prison and individual cases were tackled through the medical model. The Prison Service wasn't really out there acknowledging that it had a large number of drug misusing prisoners or in fact didn't know whether it had or not in any structured way.²⁹

The ACMD (1980) suggested that the reasons for this paucity in treatment facilities included the shortage of psychiatrists in the Prison Service; failure of the Joint Consultant Programme between the Prison Medical Service and the NHS; opposition to treatment in prisons by some psychiatrists; unwillingness of prisoners to seek treatment; low concentrations of drug misusers in a single prison to make treatment viable; the

²⁹Interview (019) with civil servant, December 1997

range of sentences served by prisoners made it difficult to maintain intensive therapeutic regimes; many therapies were based on a single theory of addiction and were unacceptable to many drug misusers; prisoners often changed their minds about treatment between remand and return for sentence; and overcrowding and budget cuts made it difficult to initiate and sustain programmes.

In the late 1970s and early 1980s, the few formalised attempts at drug treatment in prisons involved some form of therapeutic community based on a democratic, collaborative, self-help ethos (ACMD, 1980). Corrections-based therapeutic communities are one of the main modes of treatment in the United States and have a long history (Pan et al, 1993)³⁰. In such units or communities in Britain, no psychotropic medication was available, consultants from the NHS were brought in and prison officers were trained to work within these regimes. The ACMD (1980) described the efforts to provide therapeutic regimes in five prisons: the Holloway Therapeutic Unit, the Annexe at Wormwood Scrubs, Grendon Psychiatric Prison, Pentonville and Feltham. The ACMD recommended that more therapeutic units for drug dependants be established on the model of those operating at Holloway³¹ and Wormwood Scrubs³² and that follow-up studies be undertaken of drug dependants who had received treatment in custody. In response, the Home Office argued that resources were not available for any further units (Home Office, 1980). In 1985, the Social Services Committee was similarly impressed

³⁰In the United States, Stay'n Out, a therapeutic community established in the New York State correctional system in 1974 showed some success in the reduction of recidivism rates for both male and female drug misusing offenders. The success of the Stay'n Out experience contributed to the beginning of a new therapeutic community movement in corrections in the United States which was facilitated by the allocation of funds for prison-based treatment by the Anti-Drug Abuse Act of 1986 (Pan et al, 1993). This new prison-based effort in drug treatment was called Project REFORM and involved the development of 16 residential programmes. The therapeutic community was selected as the key mode of treatment because of its successful track record (Wexler and Lipton, 1993). Project REFORM was continued under the name Project RECOVERY in 1991.

³¹ The Therapeutic Unit at Holloway was established in 1972 and catered for twenty women who had already withdrawn from drugs. There was a high staff to prisoners ratio including the involvement of the assistant governor, medical officer, and psychiatric and psychology staff. Three therapeutic groups of six members met at least once a week with two co-therapists, social skills workshops were run for those coming up for release, and individual therapy was also available (ACMD, 1980).

³² The Annexe at Wormwood Scrubs was established in 1972 and catered for forty prisoners with gambling, alcohol, drug and sex offending problems. Two groups of 12 prisoners met at least twice a week around alcohol, drugs and gambling addiction. There was a high staff to prisoner ratio including the involvement of two probation officers, hospital officer, prison medical officer and assistant governor (ACMD, 1980).

by what they witnessed during their visit to the Annexe at Wormwood Scrubs and reiterated the ACMD recommendation regarding the provision of further similar units.

Overall, the ACMD report received very little attention and did not have a huge impact on the prison system or prison drugs policy (Tippell, 1989; Runciman, 1996; Hamer, 1998). With reference to the 1980 ACMD report, the Social Services Committee (1985: xxxiii) noted that, 'the sad truth is that none of these recommendations have been carried out: this report would seem to have been swept under the carpet.' In order for the report to be taken seriously, the Prison Department would have had to at least acknowledge a drugs 'problem' and that existing provision was inadequate. It can be argued however that the ACMD had some success in highlighting the importance of one of their recommendations - to establish a service to co-ordinate and improve the aftercare provision available to ex-drug dependant prisoners on release.

Release and throughcare: the development of services

Much of the ACMD report focused on the release and throughcare arrangements for drug dependant prisoners which were viewed as both 'the most important and the weakest element in providing this 'comprehensive service''(ACMD, 1980: 7). Drug dependant prisoners have similar problems to other prisoners during the resettlement process, such as housing and employment, as well some specific problems related to their drug dependant status. For example, there was growing evidence that a high proportion of prisoners die from an overdose on release from prison because they cannot tolerate the same levels as they could prior to custody. A study of addict deaths in London between 1970 and 1974 indicated that ten per cent died within a few days of release from prison (Stevens, 1977 quoted in ACMD, 1980). Prisoners with a history of drug problems were often denied parole because the Local Review Committee was concerned that insufficient support was available in the community (Parole Release Scheme, 1983). The ACMD (1980) highlighted the importance of liaison and communication between drug agencies and prisons so that follow-up arrangements could be made on release. They found evidence that voluntary agencies were experiencing difficulties gaining

access to prisons to establish contact with future clients and to undertake throughcare work. The Prison Service often resisted allowing access to these agencies because many drug workers were ex-addicts or ex-prisoners themselves and because the staff turnover rates were high. On the other hand, there was also evidence to suggest that drug agencies and drug treatment centres were reluctant to become involved within the criminal justice system, particularly prisons. In many cases, they may have refused drug misusing prisoners due to time and financial constraints (Tippell, 1989), but their reluctance also reflected an underlying resistance to become involved in treatment and therapy within a coercive environment.

As a result of the findings and recommendations of the ACMD, SCODA co-ordinated a small working group to plan a service for problem drug users in prison who were eligible for parole (Parole Release Scheme, 1985). The group consisted of representatives from SCODA, NACRO, non-residential and residential drug services, Inner London Probation Service, and the Prison Service. The impetus for this initiative emerged primarily from the voluntary sector, although the prison and probation services supported it. It was originally envisaged that the service would perform a co-ordinating role between prison and services in the community, but the Home Office advised that funding would not be available for non-residential service (Parole Release Scheme, 1985). As a result, the working group developed plans for a residential facility which would be attached to the service.³³ After several years of planning and negotiation, the Parole Release Scheme (PRS) was established in 1983. The development of the PRS is characteristic of the move away from 'specialists' and towards involving 'generalists' in the work with drug misusers which occurred during the 1980s. It represented the first dedicated service for drug misusing prisoners. Adopting a pragmatic and modest approach to its work with ex-prisoners, the scheme began as a small pilot project with three main functions: to link prisoners who were eligible for parole and had a drug history with suitable post-release services; to offer a residential service through its own hostel; and to monitor its work and learn more about drug users in prison (Parole Release Scheme, 1984). In terms of

³³ In November 1982, the Escher Association for the Prevention of Addiction offered the working group a house which it intended to operate on a management agreement from the Solon Housing Association (Parole Release Scheme, 1985).

resources³⁴, the PRS had four staff, one hostel and an agreement to work with seven prisons in London and the Southeast³⁵ chosen by the Prison Department.

It was originally envisaged that the PRS would work with approximately thirty parolees per year. In reality, however, this was a huge underestimate (Tippell, 1989). As discussed in the previous section on penal policy, changes were announced to the parole system to alleviate the growing prison population in 1984. The length of sentence during which a prisoner would be eligible for parole was reduced. This meant that more prisoners were placed into the parole process and thus more imprisoned drug misusers were eligible for referral to the PRS (Tippell, 1989). In the first year of operation, the PRS received 124 requests for referral instead of the thirty originally envisaged. By 1986, the PRS had received 404 requests for referral and was receiving 1,000 enquiries per year from probation officers in relation to drugs and drug services (PRS, 1986).

An emerging policy network

Over the course of the phase 1980-1986, it is clear the work of the ACMD and the Social Services Committees on the misuse of hard drugs and the Prison Medical Service began to generate discussion and debate regarding the treatment of drug misusers in prisons. The drugs and penal policy communities began to recognise that there were important issues which needed to be addressed within prisons regarding drugs. A policy network began to emerge around drug issues in prison which operated at the sub-sectoral level or at the interface between penal and drugs policy. The main concern for this policy network was the treatment provision for drug misusing prisoners, particularly on release. Although the Home Office and Prison Medical Service remained at the core of this network, an increasing number of groups and organisations became involved at

³⁴ The Parole Release Scheme was originally a project of the Escher Association for the Prevention of Addiction and funded through a combination of Housing Corporation, Home Office and GLC grants as well as donations from charitable organisations. It had a Management Committee consisting of representatives from NACRO, SCODA, housing associations, the Prison Department and the Probation Service (PRS, 1983).

³⁵ The prisons in London and the Southeast included Camp Hill, Holloway, Lewes, Maidstone, Northey, Standford Hill, and Wormwood Scrubs.

the periphery including the probation service, SCODA, NACRO, and drug agencies. The drug issue within prisons was gradually becoming exposed and subject to greater external scrutiny and challenges.

This policy network recognised the constraints within the prison system during this period, including the difficult penal conditions and context, the lack of a formalised drugs policy, the collusion around drug issues, the professional power of the Prison Medical Service, the lack of financial resources, and the decline of the rehabilitative ideal. Rather than attempting to tackle the problem on the inside, they pursued a much more realistic and pragmatic approach by developing measures to deal with the problem on the outside through throughcare and release measures. Working within these parameters meant that they would not have to confront the problems and constraints internal to the system. The Parole Release Scheme marked the beginning of drug service development in prisons. It revealed a glaring gap in provision and highlighted the lack of understanding around this aspect of the drug problem (Tippell, 1989). In the following chapters, it will become clear that service development preceded policy development in this area. Following the work of the PRS, other drug agencies began to work within prisons and internal interest in the drug issue within the prison system began to increase. It gradually became more acceptable for drug agencies to become involved in the criminal justice system:

....the prisons started to develop an interest in drugs and drawing in outside agencies. It wasn't really so much through drugs as much as through some of the throughcare issues and pre-release groups. They started to see the value of outsiders. The drug agencies were freaking because you know we were 'right on' and we were a little bit on the edge when it came to criminal justice issues and legality. Many drug agencies shied away [from] working in prison... gradually they began to see that they could do it.³⁶

Conclusion

Although very little substantive research or evidence existed in relation to the drugs

³⁶Interview (026a) with director of drug agency, January 1998

‘problem’ in prisons during the period from 1980 to 1986, statistics on notifications and drugs offences showed increases and several official reports pointed to a growing ‘problem’. There were, however, powerful forces masking this increasing ‘problem’. Drugs, particularly cannabis, played an important control function within the prison system and prison staff were reluctant to admit that drugs were being used. A form of ‘institutionalised collusion’ emerged which kept the problem hidden from outside scrutiny. During this period, drugs were seen primarily as an ‘individual’ problem rather than a problem for the ‘institution’. Prisoners who had been identified as having drug problems were dealt with individually mainly through the medical model. However, the treatment they received was inadequate and often inhumane in comparison with community provision, particularly in relation to withdrawal programmes. Various recommendations had been made to improve treatment programmes in prison, yet the government had failed to seriously consider or implement any of them.

During this period, prisons were operating on the periphery of the drugs policy debates, similarly drugs were not central to the penal policy debates. Many of the new ideas in relation to drug misusers and drug treatment in the community had not penetrated the walls of the prison. Although the tradition of treatment and rehabilitation continued in the community by the caring professions, the discourses of ‘law and order’ and ‘just deserts’ were particularly acute within the prison environment. The objectives of drug treatment were clearly in conflict with the aims of penal policy. Moreover, treatment objectives would also be hindered in a system under crisis with its increasing population, inadequate conditions, unrest and overcrowding. The idea that prison should be regarded as an opportunity for drug treatment also conflicted with the fact that drugs, both illegal and legal, were used as mechanisms of control in the prison environment. Those lobbying for change recognised the power of this punitive framework, but rather than tackling the problems on the inside, chose to tackle it in the community on release.

A key figure in prison drugs policy described the early 1980s as a period of ‘modest ambitions’ in relation to developments in both policy and service provision.³⁷ Although

³⁷ Interview (003) with director of drug agency, October 1997

no concrete prison drugs policy or strategy emerged during the period from 1980 to 1986, it was an important phase in that it laid the foundations for later policy developments. External interest in drugs and drug misusers in prison was growing and a small policy network was beginning to form around the issue. The Prison Medical Service had always had a monopoly over the control of drug treatment in prisons, but this began to change as more external drug agencies became involved in treatment provision in prisons from the mid-1980s. By 1986-87, drugs policy became increasingly shaped by the HIV/AIDS crisis. The next chapter will explore the impact of HIV/AIDS within the prison system and on policy development.

Chapter Four

1986-1993: The HIV/AIDS crisis and fears of contamination

Introduction

This chapter focuses on the period 1986 to 1993 which signalled the beginning of more explicit policy development in relation to drug issues in prisons. As in the previous phase, the issues of throughcare and treatment continued to be emphasised, resulting in a more formal policy document on throughcare in 1987 (HM Prison Service, 1987) and a manual dealing with guidelines on how drug misusers should be cared for within the prison system in 1991 (HM Prison Service, 1991). The HIV/AIDS crisis was the key factor precipitating this move towards a more defined prison drugs policy. In 1986, HIV/AIDS first began to be debated in relation to drugs policy in the community (Stimson and Lart, 1991; Berridge, 1996a). In contrast to the earlier phase, the 'denial' and 'collusion' which existed around drug issues in prison were no longer sustainable in light of the HIV/AIDS crisis and the evidence and research base which was beginning to emerge on the nature and extent of the problem. The concern around HIV/AIDS and injecting drug misuse within the prison environment resulted in a policy network forming around this issue which began to pressure the Prison Service to acknowledge and respond to the problem.

During the period 1986 to 1993, the macro public policy context continued to be shaped by the reforms and restructuring initiated by the Conservative government. The discourses of managerialism, value for money, privatisation, devolvment, voluntarism, partnership and community were becoming dominant features of the public policy and political landscape. These were evident in the reforms to the NHS, education and local government as well as criminal justice policy. The main thrust behind the reforms and restructuring was to shift the state towards the role of facilitator rather than provider (Atkinson and Savage, 1994). However, as Reiner and Cross (1991: 7) argue, two

contradictory trends can be identified: the devolvement of responsibility from official agencies to the community and the enhancement of power and control within central government. These themes and trends influenced the development of drugs and penal policy during 1986 to 1993.

The chapter begins with a brief outline of the major developments in drugs and penal policy which provide the context for the emerging policy on drugs in prisons. Key themes in drugs policy included moves towards greater use of harm minimisation and risk reduction approaches, an emphasis on drugs prevention, expansion and diversification of service provision, drives towards community, partnership and collaboration and increasing decentralisation. However, the enforcement and penal discourses which had become more prominent during the mid-1980s were also maintained within drugs policy. As Collison (1993) argues, the distinction between the victims and villains of drugs became increasingly difficult to draw in theory and practice. The failure to eradicate crime during the early 1980s led to changes within penal and criminal justice policy. The rhetoric of 'law and order' was diluted by the rhetoric of 'community' (Reiner and Cross, 1991). Reflecting the financial implications of increasing crime and imprisonment rates, the government began to adopt a more rational and pragmatic approach which placed more emphasis on 'just deserts' and 'punishment in the community'. During this period, the Woolf report, the 1991 Criminal Justice Act, and changes within the Prison Medical Service represented important attempts at reform within the prison system, but failed to have a radical impact, particularly on the development of prison drugs policy.

After examining these policy contexts, I then go on to explore the nature and extent of the drugs 'problem' in prison and how it was reconceptualised by key actors during this phase. By the late 1980s, there was growing external and internal interest in the problem of drug misuse and its link to HIV/AIDS. The policy network which formed around this issue effectively challenged the view that the drug problem in prison was insignificant. The Prison Service began to take a more public and prominent interest in the issue. Because prisons were seen to be a key site for HIV transmission, fears of contamination into the 'general population' propelled policy-makers to respond to the problem. The

final section of the chapter examines the policies developed around drugs and HIV/AIDS in prisons during this phase. It will emerge that these policies were inadequate, failing to fully embrace the concepts of 'risk reduction' and 'harm minimisation' and the public health agenda which were successfully operating in the community. In effect, it appears that they were designed to appease critics and give the impression that action was being taken (Edelman, 1971).

Drugs policy context: the policy discourses of 'harm minimisation', 'public health', and 'partnership'

During the period 1986 to 1993, official indicators showed that the drug problem continued to grow. With the exception of a decrease between the years 1986 and 1987, the number of new drug addicts notified to the Home Office increased steadily from 5,325 in 1986 to 11,561 in 1993 (see Table A.3, Appendix A). The heroin 'epidemic' of the early 1980s, however, appeared to be levelling off as the percentage of newly notified heroin addicts fell from ninety-one per cent in 1986 to seventy-eight per cent in 1993. The number of drug offences during this period had also increased threefold from 23,905 in 1986 to 68,480 in 1993 (see Table A.2, Appendix A). As a result of the crack cocaine 'crisis' in the United States during the latter half of the 1980s, there was growing political and media concern regarding increasing use of cocaine in the UK. However, the addict statistics failed to show a significant problem, with the proportion addicted to cocaine accounting for less than ten per cent throughout the period 1986 to 1993 (Home Office Statistical Bulletin, 1987; 1988; 1989; 1990; 1991; 1992; 1993a; 1994a; see also Power, 1994 and Bean (ed), 1993).

By the end of 1985, HIV infection was already established within drug injecting populations in England, Wales and Scotland. For example, fifty-five cases of HIV infection among injecting drug users were reported in England and Wales and 356 cases in Scotland (Robertson, 1994). Local studies conducted by Dr Roy Robertson and his colleagues in Edinburgh pointed to a rapidly spreading HIV epidemic amongst the drug injecting population, with sero-positive levels of around fifty per cent (Robertson et al,

1986). This epidemic was associated with a shortage of clean syringes and 'shooting galleries' where as many as thirty drug misusers would gather to share a single syringe. The way in which the drug problem was framed and defined changed in light of the HIV/AIDS crisis. Injecting drug users were expected to be one of the key groups in terms of heterosexual transmission and therefore seen as a threat to public health. Drugs policy became shaped and reinforced by the advent of HIV/AIDS. The main response was to re-examine harm minimisation policies and to continue the emphasis upon collaboration, co-ordination and partnership between agencies and services.

HIV/AIDS and harm minimisation

The interest and concern regarding the relationship between HIV/AIDS and injecting drug misuse were minimal initially. During the early period of the virus, key players in the drugs world were slow to come forward and many lacked expertise in relation to HIV/AIDS. Virginia Berridge (1996a: 93) argues that although a liberal consensus had been achieved in mainstream AIDS policy by 1986-87, this was initially difficult to extend to the area of drugs due to problems with political and public approval around harm minimisation techniques such as syringe exchanges, the isolation of drugs policy psychiatrists from public health and clinical medicine, and the traditions of local drugs policy-making. Conflicts and divisions were also rife within professional groups in terms of the choice between abstinence and harm minimisation approaches. However, the epidemic amongst drug injectors in Scotland and the subsequent McClelland Committee recommendations helped to impact upon a future policy of harm minimisation (Berridge, 1991; 1996a). In 1986, the McClelland Report concluded: 'the gravity of the problem is such that on balance the containment of the spread of the virus is a higher priority in management than the prevention of drug misuse' (Scottish Home and Health Department, 1986: 1).

In 1987, the UK government initially implemented three measures to tackle the spread of HIV through injecting drug misuse including an AIDS and drug misuse publicity campaign, provision of extra resources to drug services, and the introduction of fifteen

pilot needle exchange schemes (ACMD, 1988). The ACMD established a working group chaired by Ruth Runciman to discuss and consider the implications of HIV/AIDS for drug misuse services and to make recommendations on how the problem should be tackled. The group produced three influential reports on the topic (ACMD, 1988; 1989; 1993). Similar to the McClelland committee in Scotland, the ACMD (1988: 1) concluded in its first report that 'HIV is a greater threat to public and individual health than drug misuse'. Thus, the containment of the virus was viewed as more important than the prevention of drug misuse (Stimson, 1990b; Berridge, 1991). The drugs policy community increasingly recognised that many drug misusers may not wish to stop injecting and that risk reduction and harm minimisation strategies¹ must be developed to work with this group. Research evidence from the pilot syringe exchanges also indicated that they had been successful in attracting clients and changing risk behaviour, but less successful in retaining clients and attracting women and young people (Stimson et al, 1988). Policy-makers were eventually persuaded that harm minimisation strategies must be adopted to contain the virus and the threat of leakage into the general population. As Berridge (1996a: 95) argues, the gap between the 'political' and 'policy community' views on drugs policy narrowed and an alliance or consensus developed which was based on harm minimisation rather than eradication or cure. Drugs had become a problem of public health rather than individual pathology (Berridge, 1996b). Harm minimisation was officially adopted as a policy goal and involved the extension of syringe exchange schemes², free distribution of condoms, education around injecting and sexual practices, and increased use of methadone prescribing. The new language of risk reduction, harm minimisation, accessibility, and user friendliness became the 'official' discourses in relation to HIV/AIDS and drugs (Stimson and Lart, 1991).

¹The terms 'risk reduction', 'harm reduction' and 'harm minimisation' are terms which are often used interchangeably. I am employing the term 'risk reduction' to refer to measures or strategies designed to reduce the risk of HIV transmission from risky behaviour of any kind (ie. including drugs, sexual behaviour, tattooing etc.) or from accidents. 'Harm minimisation' or 'harm reduction' will refer to those measures or strategies specifically designed to minimise or reduce the harm associated with drug misuse both on an individual and societal level. Strang and Gossop (1994: 347) suggest that in harm minimisation strategies, 'the driving force is not the drug taking or abstinence of the drug users, but the extent to which harm has been reduced as a result of the intervention. This may occur at the level of harm for the individual, or harm for the broader population.'

² By the end of the 1980s, over 120 syringe exchange schemes were operating in England and Wales (Lart and Stimson, 1990).

The HIV/AIDS epidemic and the shift towards greater harm minimisation also brought new players into the field including infectious disease specialists, public health professionals, GPs and a re-shaped voluntary sector (MacGregor, 1998a). Although at one level the response to HIV/AIDS indicated a partial re-medicalisation of drugs policy, the emphasis on involving generalists such as community workers, outreach workers, and ex-addicts in drugs interventions continued (Stimson, 1990b). More funds were made available for drug services. The Central Funding Initiative in the mid-1980s had produced a wide range of new drug agencies which were in place and ready to adapt and respond to the HIV/AIDS crisis. In 1988/89, an extra three million pounds and in 1989/90, an extra five million pounds were made available for drug services to increase their role in halting the spread of HIV (Home Office, 1990b). Such funding enabled many of these services to survive. However, in order to meet the requirements of HIV funding, many services were bent towards responding to HIV and injecting drug use, to the exclusion of other drugs and other drug misusers (MacGregor, 1998). HIV had a profound effect on the way in which drug services operated. Accessible services which operated outreach, open-door and user friendly policies were developed and big targets such as abstinence were replaced with smaller targets and a hierarchy of goals (Stimson, 1990b). Moreover, their traditional autonomy was increasingly eroded, they were asked to collaborate with other agencies, become part of a wider planning process and accountable for large sums of earmarked finance (Cranfield et al, 1994).

As argued in the previous chapter, drugs policy during the mid-1980s was set within an increasingly penal framework and more focused on enforcement issues than previously. The HIV/AIDS epidemic was seen to have the effect of overturning that policy. However, as Berridge (1996a) argues, the reality was much more complex. HIV/AIDS did not overturn the penal response nor did it introduce brand new concepts into the drugs policy debate. During the period 1986-1993, the 1985 national drugs strategy was not revised in any significant way in response to the HIV/AIDS crisis and its five main action points remained unchanged.³ The bifurcated policy of control endured with

³ In 1990, the Home Office published a summary of achievements in relation to the 1985 strategy and this included an additional section which dealt with AIDS and drug misuse and included some of the guidance and advice which had been issued by the government (see Home Office, 1990b). However, this did not mark a fundamental overhaul of the strategy.

punitive enforcement measures targeted towards drug dealers and traffickers and harm and demand reduction measures for drug misusers. During the late 1980s, policy-makers, politicians and the media became increasingly concerned and preoccupied with the notion that crack would threaten the stability of British communities. They feared that the crack 'epidemic' amongst black people in some inner cities in America would reproduce itself in Britain, particularly in areas where there was a significant black population (Bean, 1993). The panic around crack ensured that the 'war on drugs' continued and provided legitimacy for the existing penal framework⁴. Two very contradictory discourses - enforcement/punishment and harm minimisation/public health - continued to operate simultaneously and were articulated publicly at the political level. As Edelman (1984) argues much political mileage can be gained by putting forward soft and hard approaches simultaneously. Such a strategy appeases both liberal critics and hard-line law and order advocates. It is possible to draw a discursive distinction between the legitimate, deserving victims and the illegitimate, undeserving villains of drugs, whereby the victims receive treatment and harm reduction and the villains receive punishment and custody (Collison, 1993; 1994). However, as Collison (1993: 383) cogently argues, in practice this distinction is simplistic and the two sides of the 'British System' are frequently dealing with the same groups of people (ie. low level dealers drawn into the criminal justice system who are also problem drug misusers).

During 1986–1993, there were also indications that drug issues in the criminal justice system, particularly in relation to prisons, were moving into mainstream drugs policy debates. Since their report on prisons in 1980, the ACMD showed a renewed interest in the criminal justice system. In the series of reports on AIDS and drug misuse (ACMD, 1988, 1989; 1993), the special problems around the link between HIV and drug misuse in prisons were specifically highlighted. In 1990, the Criminal Justice Working Group of the ACMD was appointed.⁵ It explored the various aspects of the criminal justice system

⁴The crack epidemic failed to materialise in Britain (see the edited collection by Bean (1993) for a comprehensive and detailed analysis of this issue).

⁵Their initial terms of reference were 'to examine and report on aspects of the criminal justice system as they affect drug misusers and on measures to improve their effectiveness. As a first step, to consider and advise, in the light of the Government's White Paper on Crime, Justice and Protecting the Public (Cmd 965), on measures to secure effective liaison between the Probation Service and other agencies concerned with the treatment of drug misusing offenders in the community' (ACMD, 1991: 1).

in relation to drug misusers in three major reports dealing with probation, police, and prison (ACMD, 1991; 1994; 1996). Policy networks began to form around each of these issues. The membership of the Criminal Justice Working Group varied according to the subject area, but many of the representatives had continuous membership, including Ruth Runciman who chaired each group. The membership was generally comprised of officials from the Home Office, Department of Health, Crown Prosecution Service, and the Scottish Office, psychiatrists, social researchers, and representatives from probation, police, social services, magistrates, and drug agencies.

Although the response to HIV/AIDS was perceived to be radical, this was only possible because of powerful historical antecedents (Berridge, 1991). Harm minimisation was not a new or unusual discourse, but one which had a long history and strong tradition in Britain dating back to the Rolleston era. The response was therefore based on what had gone on before. As Berridge (1996a: 95) suggests, the AIDS epidemic re-emphasised and gave political legitimacy to issues in drugs policy which were already on the agenda within the drugs policy community. Alongside the penal response, drug services had been expanding through the CFI and becoming integrated with general health provision, harm minimisation was advocated, and partnership, prevention and 'community' were being re-emphasised.

The drive towards partnership, community and prevention

During the period 1986-1993, there were further calls for improved partnership and collaboration between services and agencies around drug issues, a renewed stress on drugs prevention and moves to involve the community in tackling the drug problem. The emphasis on partnership, collaboration and involving the community were evident in other policy areas such as crime prevention, urban regeneration and health promotion. As MacGregor (1998a: 149) argues, the language and structures of the new managerialism were proposed to weld together 'the pieces of a more diverse and potentially fragmented system' and 'represent a standard form of new regulation'. Some of these ideas are based on American drugs, urban and crime policies and have been transferred to Britain.

For example, in 1989 the Office for Substance Abuse Prevention (OSAP) in the United States began a programme of funding for the development of 250 community coalitions around the country to prevent drug abuse. Similarly, in 1989 the Home Secretary announced plans to establish the Home Office Drugs Prevention Initiative (DPI) in response to fears about increases in drug misuse, drug-related illness, and crime. In the first phase, twenty local drug prevention teams were established throughout England, Scotland and Wales. The aim of these new structures was to involve all sectors of the community in tackling drug misuse and assist in the development of community initiatives around drugs (Home Office CDPU, 1993).

Collaboration between agencies and services at local level also continued to be stressed through the DDAC structures. In terms of dealing with HIV/AIDS, the ACMD (1988; 1989; 1990) recommended that DDACs should ensure the availability of clean injecting equipment, develop links with prisons, provide advice to District Medical Officers, develop links with AIDS advisory committees and encourage agencies to develop their own training plans in relation to drugs and HIV/AIDS issues. The Department of Health also endorsed the need for multi-agency working in planning and developing services. For example, when funding was announced for the expansion of needle exchange schemes within pharmacies, it was suggested that DDACs should be consulted by health authorities in drawing up local plans (Department of Health, 1992b) and that plans for alcohol and drug services within community care should be developed by local authorities, health authorities, probation service and other specialist providers in collaboration (Department of Health, 1993). Furthermore, the interface between criminal justice agencies and other agencies in DDACs was becoming more apparent. For example, it was increasingly recognised that DDACs would have to engage with prisons particularly around HIV/AIDS issues because prisoners were seen to be a key population in relation to the transmission of the disease. The Department of Health (1988) suggested that a framework was required to enable local collaboration with prisons built either around the 'adoption' of prisons by local health agencies for health care services or with prison education services. Similarly, the ACMD (1991) made recommendations that the Probation Service should collaborate with health and local authorities regarding the treatment of drug misusing offenders and play a role in the preparation of and

consultation on community care plans.

Despite these numerous recommendations and moves towards joint working, the system of collaboration and particularly DDACs were not working effectively (Baker and Runicles, 1991; Dorn and South, 1994; Howard et al, 1994). Several problems associated with joint working were identified in a report by the London Research Centre and the National Local Authority Forum on Drug Misuse: some areas did not have functioning DDACs; membership was dominated by the health service; irregular attendance was common; support structures were weak; terms of reference were vague; there was little involvement in resource allocation decisions; difficulties arose over non-coterminous boundaries; seniority levels amongst members varied; there were difficulties in ensuring commitments to joint working; social services were not aware of drug issues; and DDACs had not been incorporated into the formal planning machinery (Baker and Runicles, 1991). In 1992, the Department of Health commissioned Roger Howard and his colleagues to identify good practice and make recommendations for new collaborative arrangements to tackle drug misuse. Howard et al (1994:9) proposed new partnership structures to replace the existing DDACs and predicted that the role of the criminal justice system would feature prominently in any future collaborative arrangements:

The criminal justice system remains a key area of change for tackling drugs misuse, which statutory and voluntary agencies will need to address together. The boundaries of what constitutes enforcement and what constitutes prevention, treatment and care are being redrawn.

Penal policy context: key attempts at reform 1986-1993

During the latter half of the 1980s, the penal crisis continued, culminating in serious riots at Strangeways and other prisons in 1990. This was described by Sparks et al (1996: 15) as the 'most drastic and public notorious event in the modern history of the prisons of England and Wales'. During the late 1980s and early 1990s, several attempts were made

to manage and contain the crisis in British prisons. The emphasis on economy, effectiveness and efficiency continued and the discourses of managerialism and privatisation began to manifest themselves in more concrete and visible ways. For example, in 1987, the Fresh Start initiative was introduced which involved a fundamental overhaul of working arrangements for prison officers and management structures. This package of reforms was implemented rapidly leading to alienation, disillusionment and dissatisfaction amongst prison staff and ultimately more industrial action by the Prison Officers' Association (POA). Moreover, research conducted by McDermott and King (1989) found that regimes were more likely to deteriorate under Fresh Start than to be enhanced. By the late 1980s, the issue of prison privatisation was also gradually creeping onto the political agenda. Many of the advocates argued it was the solution to the penal crisis (see Adam Smith Institute, 1984; Young, 1987). In July 1987, the Home Secretary, Douglas Hurd announced in the House of Commons that privatising prisons was out of the question. However, a rapid and radical shift in policy ensued as a result of a report by the House of Commons Home Affairs Select Committee (1987), vigorous lobbying by a group of backbench Conservative MPs and Lord Windlesham who was chair of the Parole Board (Ryan and Ward, 1989). In 1989, it was announced that two remand prisons would be handed over to the private sector to manage on an experimental basis (Hansard, 1 March 1989, col 278). In 1992, Wolds remand prison on Humberside was contracted out. However, before it could be evaluated, an amendment to the 1991 Criminal Justice Act allowed for the extension of privatisation to the mainstream prison population (Ryan and Sim, 1998).⁶

As discussed in the previous chapter, with the decline of the rehabilitative ideal, the 'just deserts' approach to sentencing moved to the forefront of penal policy (von Hirsch, 1976; 1985). Penal policy during the late 1980s and early 1990s was in the direction of making punishment proportionate to the gravity of the offence, making 'fair' punishment the main penal aim rather than the reform or rehabilitation of offenders, reserving imprisonment for serious offences, and substituting community penalties for short prison sentences for non-violent crimes (Hudson, 1993). During the period 1986 to 1993, two

⁶ By 1995, four prisons catering for both remand and sentenced prisoners had been contracted out – Wolds, Blakenhurst, Doncaster, and Buckley Hall.

central themes were operating within the discourse on justice: 'just deserts' and 'punishment in the community' (Collison, 1993). These themes and trends underpinned the Green Paper, *Punishment, Custody and the Community* and the White Paper, *Crime, Justice and Protecting the Public*, culminating in the 1991 Criminal Justice Act which marked a significant shift in penal policy and a pragmatic response to the prison population crisis. The Act can be viewed as the outcome of careful deliberation and refinement of the relevant issues by civil servants who had consulted widely and engaged key interest groups in the debates (Faulkner, 1996; Downes and Morgan, 1997). By the late 1980s, the penal lobby was growing increasingly sophisticated in its structure and organisation and could not be ignored by policy-makers. For example, the Penal Affairs Consortium was formed in 1989⁷ and consists of an alliance of diverse organisations including penal reform groups such as the Prison Reform Trust, NACRO, Howard League and Women in Prison as well as professional associations including the Prison Officer's Association (POA), the Prison Governor's Association, and the National Association of Probation Officers (NAPO). As Downes and Morgan (1997: 114) comment, such a combination of interests was 'previously unthinkable'.

1991 Criminal Justice Act

In 1988, the Green Paper, *Punishment, Custody and the Community*, presented a compromise which would shift middle-range sentencing away from custodial punishments towards community-based sanctions, simultaneously making these sanctions more punitive in their content and public imagery. Prison would be reserved for the most serious and violent offenders. The proposals aimed to increase the courts' and the

⁷ The Penal Affairs Consortium presents joint views to Government, Parliament, the media and the public regarding penal reform (see for example, Penal Affairs Consortium, 1995). The membership grew from thirteen members in 1989 to thirty-one members in 1996 consisting of Apex Trust, Association of Chief Officers of Probation, Association of Members of Boards of Visitors, Bourne Trust, Civil and Public Services Association, Federation of Prisoners' Families Support Groups, Howard League, Inside Out Trust, Institution of Professionals, Managers and Specialists, Justice, Liberty, NACRO, National Association for Youth Justice, NAPO, National Council for Social Concern, National Forum of Care Trusts, the New Bridge, Prisoners Abroad, Prisoners' Advice Service, Prisoners' Families and Friends Service, Prisoners' Resource Service, Prison Governors' Association, Prison Officers' Association, Prison Reform Trust, Release, Royal Philanthropic Society, Society of Voluntary Associates, Standing Committee for Youth Justice, Suzy Lamplugh Trust, and Women in Prison

public's confidence in keeping offenders in the community rather than in custody. The three underlying principles of the Green Paper were punishment, action to reduce further offending, and reparation to the community and compensation to the victim (Home Office, 1988a). Essentially, this was a flexible, hybrid approach which appealed to both the 'law and order' lobby as well as penal reformers, as it could appear both 'tough' and 'soft' at the same time. It encouraged increased use of community sanctions, but within a more punitive framework, shifting the balance away from the 'welfare approach' in the community towards penal values (Garland, 1989). In this view, community-based sanctions assume the attributes of punitive sentences.

In 1990, the White Paper, *Crime, Justice and Protecting the Public*, carried through the principles of desert-based sentencing put forward in the Green Paper and advocated a new sentencing framework. The discourses of deterrence, reform and rehabilitation were no longer present. The emphasis was now placed on proportionality, just deserts, retribution, incapacitation, and protecting the public. Prison should be reserved only for the most serious offenders, as it was considered ineffective in reforming the majority of prisoners and an 'expensive way of making bad people worse' (Home Office, 1990a: 6). The 'just deserts' reforms set out in the White and Green papers came into force in October 1992. The 1991 Criminal Justice Act was founded on the following principles: the severity of the sentence should reflect the seriousness of the offence; sharper distinction between property offences and offences against the person (sexual and violent offences); procedures for administering sentences should be rigorous and fair so as to ensure that the sentencer's intentions are properly reflected in the way in which the sentence is served; community penalties should play a full part in their own right in the structure of penalties; young people should be dealt with in a way which reflects their age and development; and the criminal justice system should be administered efficiently and without discrimination (Ashworth et al, 1992: 19-20). The overall aim of the 1991 Criminal Justice Act was to reduce the use of custody⁸, rather than tackling the 'crisis of

⁸ There was evidence that this strategy was partially effective in the short-term. For example, the proportion of custodial sentences passed dropped from sixteen per cent in the period January to September 1992 to twelve per cent in the period October 1992 to December 1992 (Home Office, 1993b, para 7.11) and the prison population also decreased by approximately 500 per month in the second half of 1992 (Home Office Statistical Bulletin, 1993b: 3).

legitimacy' which had been plaguing the penal system. As Hudson (1994: 294) argues, the 1991 Act prioritised 'acts' over individuals and legal facts over social facts as rehabilitation professionals lost power and sentencers moved to the forefront of the penal response.

With regard to drug offenders, the Act pursued a bifurcated approach allowing for harsh punishments for drugs traffickers and treatment and diversion from custody for less serious offenders with drug problems. Sentencers were enabled under the Act to attach an additional requirement to probation orders - that the offender should undergo treatment for drug or alcohol dependency. In theory this meant that more drug misusers would be brought into contact with the treatment services, thus locating this group of less serious drug misusing offenders outside the general framework of 'punishment in the community' and 'just deserts', by prioritising drug problems over crime problems (Collison, 1993). The Act also put forth new arrangements for local funding and partnership whereby local probation services were expected to develop agreements with the independent sector and other agencies on best practice in dealing with offenders in the community.⁹ Funding of voluntary organisations, some of which deal with drug issues, would be passed from the Home Office to local probation services. As a result, probation services would have more of a role in commissioning. However, research conducted by Lee (1994) suggests that within the first six months after commencement of the 1991 Act, very few conditions of drug treatment were made and it was debatable whether those which were imposed were actually being used as alternatives to custody. Various factors could have contributed to their low take-up rates including their lack of credibility amongst sentencers as a sentencing package for more serious offenders and the competition between the various types of community punishments; the financial constraints of both probation services and drug agencies; the problems around assessment and disclosure of drug problems amongst offenders and questions regarding the motivation of offenders towards treatment (Collison, 1993; Lee, 1994). In practice,

⁹Under the new arrangements for delivering punishment in the community, there was increasing emphasis upon inter-agency cooperation between the probation service, the police, local authorities and the community. The probation service was to play a central role in the management of supervision programmes, but would no longer be the exclusive provider of services and facilities. Greater use of the skills and experience in the voluntary and private sectors was encouraged (see Home Office, 1990f, 1990g, 1991b, 1992; ACMD, 1991).

the welfarism and treatment orientation of the 1991 Act was abandoned for increasing repression, punishment and criminalisation of addicted offenders and drug-related crime (Collison, 1993; Henham, 1994). Women, particularly foreign nationals working as drug 'mules', have become the victims of such policies as more and more are sentenced for drug trafficking offences (see Green, 1991; 1996).

The Woolf inquiry

After the riots at Strangeways and other prisons in 1990, Lord Justice Woolf and Judge Stephen Tumin were called upon to conduct an inquiry into their causes. Downes and Morgan (1997a: 116) describe the Woolf Inquiry as a 'model of democratic participation by an informed citizenry'. The Inquiry employed an open and consultative style and used a variety of techniques such as public hearings and seminars, eliciting views of prisoners¹⁰ and prison staff through letters, written evidence from interested individuals, agencies and organisations, a prison seminar for prisoners and prison staff, and visits to prisons in England and Wales, Scotland, Canada, France, Germany, the Netherlands, Spain, and USA.¹¹ The report derived from this consultation and analysis represented an important attempt at reform within the prison system. Although Woolf concluded that there was '...no single cause of riots and no simple solution or action which will prevent rioting' (Woolf and Tumin, 1991, para 9.23), he identified three requirements that must be met and balanced if the prison system was to remain stable: security, control and justice.¹²

The programme of change proposed by Woolf involved 12 main recommendations¹³ and

¹⁰ However, Sim (1994: 35) argues that the accounts and evidence provided by prisoners were treated with scepticism.

¹¹ See the Annexes 2A-2R of the Woolf Report (Woolf and Tumin, 1991: 459-553) for more detail on the consultative techniques used by Woolf and Tumin and the complete lists of which organisations and individuals participated and provided evidence.

¹² Within this framework the Prison Service has three obligations: security refers to the obligation 'to prevent prisoners escaping', control refers to the obligation 'to prevent prisoners being disruptive' and 'justice' refers to the obligation to 'treat prisoners with humanity and fairness and to prepare them for their return to the community in a way which makes it less likely that they will offend' (Woolf and Tumin, 1991: para 9.20).

¹³ These recommendations included: closer co-operation between the different parts of the criminal justice system; more visible leadership of the Prison Service by a Director General; increased delegation

was greeted favourably across the political spectrum resulting in a consensus amongst politicians, civil servants, the media, most academics and penal reform groups. The report had 'transcended the divisions' between these groups and united them on the 'ideological terrain of penal reform' (Sim, 1994: 42). Others argued that Woolf's analysis was consistent with contemporary penal practice and discourse and did not offer any radical analysis of the prison system (see Hudson, 1993; Sim, 1994). In particular, Woolf failed to address the problems in women's prisons and the racism inherent within the system (Carlen and Tchaikovsky; 1996; Hudson, 1993). In addition, he failed to address the purposes of imprisonment in any comprehensive or detailed way. The current Prison Service Statement of Purpose was endorsed by Woolf:

Her Majesty's Prison Service serves the public by keeping in custody those convicted by the courts. Our duty is to look after them with humanity and to help them lead law abiding and useful lives in custody and on release (Prison Department Mission Statement, November 1988).

However, Woolf pointed out two caveats to his acceptance of the statement of purpose. Firstly, Woolf was critical of the absence of any reference to justice and secondly, he did not believe that the statement adequately covered unconvicted prisoners. Although Woolf's brief analysis does not advocate a new statement of aims, it did show some promise in opening up the debate again regarding the purposes of imprisonment and promoting a system based on justice. As Morgan (1994: 111) argues this had the potential to unlock 'a process of logic with radical implications'. Woolf had placed the notion of 'justice' at the centre of his conceptual framework in an attempt to resolve the crisis of legitimacy within the prison system (Sparks, 1994; Sparks and Bottoms, 1995).

of responsibility to Governors; an enhanced role for prison officers; a 'compact' or 'contract' for each prisoner setting out the prisoner's expectations and responsibilities and what the prison expects from the prisoner in return; a national system of accredited standards; a new prison rule that no establishment should hold more prisoners than is provided for in its certified normal accommodation; a public commitment from Ministers setting a timetable to provide access to sanitation for all prisoners; better prospects for prisoners to maintain their links with families and community through more visits and home leaves and being held in community prisons as near to their homes as possible; a division of prison establishments into small and more manageable and secure units; a separate statement of purpose, conditions and lower security categorisation for remand prisoners; and improved standards of justice within prisons (Woolf and Tumin, 1991: para 15.5).

In terms of implementation, Woolf made it clear that his recommendations had to be taken together as one package. The Home Secretary, Kenneth Baker, announced some immediate reforms to letters, telephone calls, visits, home leave, and sanitation on receipt of the report in February 1991. The official response to the Woolf Report was contained in the White Paper, *Custody, Care and Justice* (Home Office, 1991c) which claimed the government had accepted all of Woolf's proposals with the exception of Parliamentary control on overcrowding which would be dealt with after the 1991 Criminal Justice Act was fully operational. However, the timetable for implementation was vague in relation to the main recommendations. In the summer of 1991, Baker announced that Woolf's agenda would take approximately twenty to twenty-five years to implement and made it clear that no extra resources would be devoted to implementing his recommendations. It is evident the government responded to the proposals in a 'pick and mix' fashion rather than comprehensively as Woolf had intended. Cavadino and Dignan (1992) identify their response as a two-speed approach with security measures, such as x-ray machines and metal detectors, in the fast lane and reforms such as improved regimes, the end of overcrowding and the adoption of enforceable standards in the slow lane.

In their inquiry, Woolf and Tumin (1991) made two recommendations in relation to drug misusers in the prison system. Firstly, the Prison Service should examine the experiences of drug free units in the Netherlands, Sweden and the United States (para 12.350), and secondly a prison officer should be responsible for co-ordinating the services provided within each prison and in the locality for drug and alcohol abusers (para 12.353). On a related issue, they also called for a thorough review of the Prison Service policies in relation to HIV (para 12.372). Although medical issues were not dealt with specifically, Woolf and Tumin also expressed concern regarding the standards of medical provision available through the Prison Medical Service (para 12.131).

Changes to the Prison Medical Service

As we saw in the previous chapter, the Prison Medical Service (PMS) had been long criticised as inadequate and often inhumane in its medical treatment of prisoners. It had

been the subject of several official reports which called for urgent reform (Home Office, 1964; 1990c; 1990d; 1990e; House of Commons Social Services Committee, 1986; Woolf and Tumin, 1991). In particular, medical treatment in prisons was not considered to be of a comparable standard to that provided in the community. In 1990, the PMS and its structures were the subject of an efficiency scrutiny by the government's Efficiency Unit (Home Office, 1990c). The main recommendations of the Efficiency Scrutiny Report included that the PMS should become a health service stressing health promotion and prevention; medical management and clinical practice should be more clearly distinguished; the Prison Service should become a purchaser of health care rather than a provider; and the PMS should become as closely aligned to the National Health Service as possible.

In April 1992, the Prison Medical Service was renamed the Health Care Service for Prisoners. The aims of the new service were to provide a total system of care dealing with the whole person and to promote general health rather than being solely focused on ill health (HM Prison Service, 1992). The concept of 'healthy prisons' was also put forward, emanating from the concept of the 'healthy cities' initiatives in the community (Department of Health, 1992a). The new health service for prisoners was to encompass physical and mental health, treatment and cure, training and education, conditions and regimes. The delivery of health care to prisoners would be achieved through a multi-disciplinary approach. In addition to the new service, there would be a new Health Care Advisory Committee to provide independent advice to the Prison Service on the health and care of prisoners; new research programmes; new health care standards; rationalisation of health care services; pilot projects for contracting out health care services; a new training strategy for health care staff; and a review of services to mentally disordered offenders (HM Prison Service, 1992). In theory, these proposed changes were welcomed as they represented 'a move from a prisoner-punishment paradigm and towards a medical model, where the relationship is characterised as patient and doctor rather than prisoner and prison medical officer' (Thomas and Costigan, 1992: 332). This shift towards a more 'health' based service and the greater emphasis on multi-disciplinary approaches provided the framework and context for the way in which drugs and HIV/AIDS were dealt with in the prison system. The opening up of the prison to outside

agencies in the community had the potential to challenge the monopoly prison medical officers had over the care and treatment of drug misusing prisoners. Before exploring some of these issues, the next section will first examine the nature and extent of the 'problem' of drug misuse in prisons and how it was reconceptualised during the period 1986-1993.

The end of the denial: reconceptualising the drugs 'problem' in prison

During the late 1980s and early 1990s, the drug problem in prison was reconceptualised and framed in new ways. The problem had progressed to the stage where it could no longer be denied nor ignored. The collusion around drugs became increasingly untenable due to a number of interlinked factors – changes in the drug problem in terms of incidence and severity, the HIV/AIDS crisis and fears of leakage into the general population, an emerging policy network around HIV and drug issues in prisons, and the growing research and evidence base. The drug problem *in* prisons was finally acknowledged reluctantly by the Prison Service. This process was referred to as the 'end of the denial' by informed members of the policy network around drug issues in prisons. As a director of a drug agency argued:

There was always an absolute denial that there was any drugs in prison...Drugs are illegal therefore they don't exist. That went on right up until the early 1990s....when there was an acknowledgement that there was a drug problem in the prison setting. Before, there was always a complete and total and utter denial, partly because no one really knew what to do about it. So if we pretend it is not there, it will just go away. But it didn't, it got bigger and bigger.¹⁴

In terms of official indicators, the number of drug addicts and drug offenders in prison decreased in the latter half of the 1980s, but began to increase again by the 1990s. For example, the number of new addicts notified to the Home Office by prison medical officers fluctuated, decreasing from 1,102 in 1986 to 624 in 1989 but then increased

¹⁴Interview (004) with director of drug agency, October 1997

steadily each year until 1993 when the number reached 1,941 (See Table A.1, Appendix A). Similarly, the number of drug offenders sentenced to custody had decreased from 3,928 in 1986 to 3,268 in 1991, but then increased again to 4,835 in 1993 (See Table A.2, Appendix A) Reflecting the greater use of cautioning for drug offenders, particularly for unlawful possession, the proportion of drug offenders sentenced to custody decreased progressively from 16% in 1986 to 7% in 1993 (Home Office Statistical Bulletin, 1994b). With the 'end of the denial' and the growing public acknowledgement of the drug problem, a director of a drug agency suggested that this caused the issue of drugs in prison to grow and perhaps take on its own momentum:

One of the consequences of public acknowledgement of things is that they increase in their incidence. Yet the objective of public acknowledgement is to try and start to control them. There's a symbiotic relationship between opening issues out and acknowledging them at a national level and the issue growing as an issue...that's happened in prisons.¹⁵

The increase in the extent of the drug problem in prisons was associated with heightened awareness of the issue and concern amongst drugs experts, civil servants and other professionals that the problem was becoming more serious with an increasing number of prisoners using drugs other than cannabis. Perceptions regarding the drugs 'problem' in prisons had shifted in terms of incidence and severity. As a civil servant commented:

...In the late 1980s, there was an acknowledgement that drugs were in prison, but the perception was that it was all cannabis...Although the Service didn't admit it, the general philosophy was that this contributes to a quiet jail and wasn't causing a very great problem. I remember at that time an obsessive belief that somehow as a matter of choice prisoners were not trying to smuggle anything else into the prison other than cannabis. That was the major change...a realism with which we now view this.¹⁶

Those working within prisons suggested that heroin use had become accepted as a part of prison life. In a sense, it had become 'normalised'. The increased use of drugs, particularly Class A drugs, was beginning to pose a threat to the prison environment in

¹⁵Interview (008) with director of drug agency, October 1997

¹⁶Interview (014b) with civil servant, November 1997

terms of order and control problems. Drugs were seen to be the source of more violence, bullying and intimidation within prisons (HM Chief Inspector of Prisons, 1992). A penal reformer recalled that as drug use became 'routine' in prisons, it became a problem of control and order:

You can't authoritatively measure it, but the use of drugs in prisons - the routine use of drugs - grew massively in the late 1980s, early 1990s. The interest in what to do about it was to a significant extent a reflection of what was happening. Drug use was becoming routine in prisons...it offended against common sense ideas of 'law and order' and it was associated with intimidation and violence...it presented control problems. It certainly was a control issue¹⁷

As discussed in the previous chapter, both illegal and legal drugs were viewed as functional and used as control mechanisms within the prison system during the early 1980s. During 1986-1993, drugs were perceived to be more problematic as they became a major part of the informal prison economy. Sparks et al (1996: 122) define the 'informal economy' as an endemic control problem which consists of the following activities: gambling, money lending, the trading of goods, importation of drugs, manufacture of alcohol and other 'sub rosa' trading. Staff and prisoners in their study suggested that these activities were a part of prison life, not always a matter for serious concern and may contribute to the smooth running of an institution. Major threats to prison order result from indebtedness and extortion, rather than from the activities themselves. Staff must therefore strike a delicate balance when tackling these activities. As Sparks et al (1996: 122) argue there is a tension between 'the management of a chronic problem and how to act without destabilizing an existing situation, or losing legitimacy.' However, the link between HIV/AIDS and needle sharing within prisons highlighted the problem with 'turning a blind eye', the collusion and the failure to tackle the problem of injecting drug misuse which was seen not only as a threat to the prison population, but also to the outside community.

¹⁷ Interview (024) with penal reformer, January 1998

Another factor, perhaps the most important, which was linked to greater awareness and the reconceptualisation of the drug problem in prison was the HIV/AIDS crisis. The first prisoners in England and Wales known to be HIV positive or to have an AIDS diagnosis were received into the prison system during the period 1984-1986. The number of known reported HIV positive prisoners remained fairly stable and averaged between 40 to 70 per month from 1986-1991. During 1992-1993, this figure dropped to an average of 30 to 35 cases. By April 1995, a total of 449 known HIV positive prisoners had been reported since 1985, 30 prisoners with an AIDS diagnosis were notified, and 12 prisoners with an AIDS-related illness had died during their sentences¹⁸ (HM Prison Service, 1995: 7).

The monotony of the prison regime produces tensions which can lead to particular forms of 'escapism' such as homosexual sex amongst heterosexual men and drug misuse (Thomas, 1990). There are special conditions operating within the prison environment which have implications for the risk of HIV transmission both inside prisons and on release in the community. If a syringe is smuggled into a prison, then it is likely to be widely shared amongst prisoners (Dolan et al, 1990; Stimson et al, 1988; Turnbull et al, 1991; Covell et al, 1992). Homosexual activity does occur between prisoners, some of whom lead heterosexual lives on the outside (ACMD, 1988; Harding, 1990). Tattooing, another high-risk activity in relation to HIV/AIDS, also occurs in prisons. Self-injury and suicide attempts also carry HIV risks and are frequent occurrences in prison (Liebling and Krarup, 1993). The nature of the prison population also contains a disproportionate number of people who are likely to be at greater risk of HIV infection: young, sexually active, drug users, drug injectors, prostitutes and violent offenders (Dolan et al, 1990; Harding, 1990; HM Prison Service, 1995). The HIV/AIDS crisis provided further disincentives for drug misusers to seek help with their drug problems

¹⁸ It is important to note that all the figures quoted above represent only the confirmed cases of HIV/AIDS based on tests and therefore underestimate the total number of people in prison with HIV. No systematic, anonymous screening studies had been undertaken to estimate the prevalence of HIV at this time.

because of fear that they might be coerced into taking an HIV test, segregated from the rest of the population, and subject to stricter security, searching procedures and hostile treatment from other prisoners and prison staff (Thomas, 1994).

As we saw in the earlier section on drugs policy, drug injecting prisoners were considered to be a key population in terms of HIV/AIDS prevention, education and intervention (ACMD, 1988; 1989). The main concern was the threat of transmission to the general population. Just as HIV funding allowed for a number of developments in the drugs field, such as the move away from abstinence-based approaches and the opening up of a wider range of drug treatment options, it also enabled drug agencies to expand their work in prisons and provided the thrust for the interest in the area (Exeter Drugs Project, 1990; Parole Release Scheme¹⁹, 1991; Hamer, 1998). Although drug agencies had been working with prisoners for several years, the prison authorities showed little interest in the nature of the work they were doing as this would imply that they should be recognising the problems, developing effective strategies and providing resources to deal with the problem. There was still an underlying resistance by the Prison Service to fully acknowledge the problem of drugs and high-risk behaviour in prisons and implications for policy and practice. A director of a drug agency described the situation in these terms:

*We always had this sort of 'Cinderella' existence really. We went in, people knew we did things, but people didn't want to know what we did, because if they did know what we did, then they'd have to do something about what we did. There was this whole sort of charade that was played out.*²⁰

On the other hand, many groups had a vested interest in highlighting or 'talking up' the HIV issue in prisons as it provided new opportunities for funding and an expansion of their remit into the prison system:

¹⁹ In the summer of 1990, the Parole Release Scheme had an increase in funding which allowed them to expand their staff and workload. This was achieved through the mobilisation of regional health authority drug and HIV allocations. In addition to drugs advice and counselling, their work began to incorporate HIV training and education for prisoners and prison staff and organising forums for workers involved in HIV work in prisons (see Parole Release Scheme, 1991).

²⁰ Interview (010) with director of drug agency, November 1997

There are flavours of the year. There was HIV/AIDS when it was the flavour of the year. This meant it attracted grants. We used to call it 'positively funded'...Drugs - the war on drugs - became a hot public issue. Groups see the opportunities for funding and so it was in their interest to talk it up.²¹

The advent of HIV/AIDS eventually widened the interest around drug issues in prison. A policy network began to form around the issue which lobbied for acknowledgement of the problem and a response from the Prison Service. The key groups involved in this policy network around HIV and drug misuse included members of the ACMD (1988; 1989; 1991), drug treatment agencies (Trace, 1990), medical professionals (Farrell and Strang, 1991), penal reform groups (Prison Reform Trust, 1988; 1991), probation officers (Fletcher, 1990), HIV/AIDS organisations, health authorities, and social researchers who had been attempting to conduct research on the problem. The issue had also been flagged up during the Woolf Inquiry (Woolf and Tumin, 1991) and by Judge Tumin in his role as Chief Inspector of Prisons (HM Chief Inspector of Prisons, 1992). There was also interest in AIDS in prison at the international level. For example, the Council of Europe sponsored a study of policy and practice in seventeen European countries (Council of Europe, 1987; Harding, 1987) and the World Health Organisation also convened a consultation on the prevention and control of AIDS in prison in 1987 (WHO, 1987). It was mainly external interest, rather than internal interest in the issue which initially was driving forward policy development. As a spokesperson from a professional association argued:

All drug policies were driven by concern about HIV and AIDS then and prison was seen as being a major route of transmission back into the mainstream population. That's what made the medics interested. That's what made the drugs world interested. That meant that health authorities and treatment services wanted to get involved in prisons...The drive came from that direction rather than from within prisons.²²

²¹Interview (029) with penal reformer, February 1998

²²Interview (021) with spokesperson for professional association, January 1998

However, there is also evidence that civil servants working in the Directorate of Prison Medical Services at Prison Service Headquarters were pressuring for more systematic information on aspects of HIV/AIDS in prisons and for a more strategic approach. In particular, Len Curran, a principal psychologist, had written a number of key reports advocating change (see Curran and Morrissey, 1989; Curran 1991a; 1991b; 1991c; 1991d; 1992).

The growing research/evidence base

No official, systematic research on the extent and nature of high-risk behaviours *in* prisons, particularly on homosexuality or drug misuse, had been undertaken during this period. Reflecting the collusion around drugs and the reluctance to admit that drugs were being used in prison, as well as the general problems of gaining access to conduct research in prisons, researchers had been repeatedly denied access to prisons to conduct such research throughout the 1980s (Thomas, 1990; Pearson, 1990). Although there had been pressure for systematic information on HIV/AIDS issues, Ministers argued that the problem was small, under control, and research in this area would be fraught with methodological difficulties associated with sampling, ethics, self-report and the veracity of inmates' accounts (Curran, 1991a). There were rumours that research on high-risk behaviours in prisons had been conducted, but suppressed.²³ Illicit drug taking and, arguably, homosexual sex in prisons constituted disciplinary offences for which any prisoner who took part in these activities was liable to be punished. There was therefore no official recognition from the government that drug misuse or homosexual sex were significant 'problems' within prisons. As Thomas (1990: 2) argues, the lack of evidence and the formal, legalistic reaction allowed for an 'official' discourse to emerge which suggested that the incidence of homosexual activity, drug misuse and drug injecting were minimal and therefore the threat of HIV was not a major problem and did not require radical action.

²³This was indicated by several respondents in this piece of research as well as by Berridge's analysis of the development of AIDS policy (see Berridge, 1996a: 225).

By the early 1990s, another set of data and an 'unofficial' discourse were also beginning to emerge which questioned and challenged the 'official' discourse. Researchers eventually managed to gain limited access to prisons and to samples of ex-prisoners which enabled them to begin to construct a picture of the problem. Research began to show that a substantial proportion of prisoners had been dependent on drugs prior to imprisonment²⁴ (Maden et al, 1990;1991); illegal drugs were available in prisons (HM Chief Inspector of Prisons, 1992; Turnbull et al, 1994); drug use in custody was fairly widespread²⁵ (Turnbull et al, 1991), injecting and sharing needles was common within custody (Stimson et al, 1988; Donoghoe et al, 1989; Dolan et al, 1990; Dye and Issacs, 1991; Carvell and Hart, 1990; Kennedy et al, 1991; Turnbull et al, 1991; Bird et al, 1992;1993; Power et al, 1992; and Covell et al, 1993); the number of needles and syringes found in prisons had increased consistently between the years 1985 and 1989 (Turnbull et al, 1991); and the first reported outbreak of HIV infection in a prison in Britain was reported at Glenochil prison in Scotland in 1993 (Christie, 1993). In terms of homosexual activity, there was still a lack of evidence. However, based on reports from prison staff and ex-prisoners, Curran and Morrissey (1989) estimated that between ten and fifty per cent of the long-term male prison population may engage in homosexual activity at some time during sentence. In relation to tattooing, Dolan et al (1991) found that seven per cent of a total of 98 drug injectors reported sharing tattooing equipment when they were in prison.

Much of the existing research and evidence quoted above has focused on male prisoners. There has been a real lack of attention paid to needs and circumstances of female prisoners. Another limitation of the research is that much of it has been based on small sample sizes and samples of ex-prisoners. Despite its methodological flaws, this research

²⁴ A survey involving a random sample of 272 women serving a prison sentence revealed that 23% could be defined as dependent on drugs and 15% had injected drugs in the six months preceding imprisonment (Maden et al, 1990). A similar survey conducted with a random sample of 1751 men serving a prison sentence showed that 11% were defined as dependent on drugs and 7% had injected drugs in the six months prior to imprisonment (Maden et al, 1991).

²⁵ A study involving a sample of 452 ex-prisoners in England revealed that over half (55%) reported that that used at least one drug in custody. The most frequently used drug was cannabis, but one in five reported heroin use (Turnbull et al, 1991).

played an important role in raising awareness of the problems in prison and placing these issues on the policy agenda. Curran (1991a: 18), a civil servant in the Directorate of Prison Medical Services, conceded:

The department has been nervous of research into HIV seroprevalence and into risk behaviour in prison. In retrospect such an approach has merely served to attract criticism from a number of influential and vocal sources. The research has proceeded outside and has suffered from sampling problems and small sample sizes. This has not deterred wide dissemination of the results and has heightened rather than decreased speculation on risk behaviours.

The media also played a role in constructing both HIV/AIDS and drug misuse as problems in prisons by heightening interest and making these issues more visible. In 1989, the BBC produced a Panorama programme entitled, *The Killer Inside*, which focused on drug misuse in prisons, needle sharing and HIV/AIDS. The reporter, Robin Denselow, interviewed prisoners and staff in Wandsworth, Saughton, and Stafford prisons. The interviews revealed that drug injectors were sharing needles in prisons. One prisoner claimed they had two sets of 'works' between 30 prisoners, while another prisoner who was HIV positive was sharing a needle with 20 other prisoners who were aware he was infected with the virus. In many ways, this programme amplified the issues of drugs and HIV/AIDS (Cohen, 1972), but it also helped to highlight the plight and treatment of HIV positive prisoners and the lack of policy response. At the time, this was a particularly powerful programme and had much impact in terms of raising awareness around the issues and placing them on the policy agenda.²⁶

This growing research and evidence base corresponds to the 'enlightenment' model of research utilisation (Weiss, 1986), whereby a body of evidence accumulates over time eventually sensitising policy-makers to new issues and shaping the framing and conceptualisation of problems. It also corresponds to the 'interactive' model where research, information, and data are pooled by a diverse range of actors such as civil servants, journalists, interest groups, practitioners and professionals in order to make

²⁶ Interview (023) with spokesperson for professional association, January 1998

sense of the problem. The research was used by the policy network to pressure for a different response in relation to the problems of drugs and HIV transmission in prisons (Berridge, 1996a) and to force a public acknowledgement that drugs were being used in prisons. Once this information was published and in the public sphere, it meant that the problem could no longer be denied and ignored by the Prison Service or the government. As a spokesperson from a professional association argued, it was no longer politically possible to deny the existence of a problem:

...once the thing becomes public, once you say there are people using drugs in prison, you then get a political dynamic happening. The professionals are quite happy for people to be using drugs in prison as long as it's cannabis, as long as they're not injecting. But politically it becomes untenable for the government to allow prisoners to engage in illegal activity while they're supposedly serving a sentence. That is unacceptable to Daily Mail-driven public opinion. It then becomes unacceptable for politicians. That ratchets the awareness up that much more.²⁷

The interest around the drug problem in prison reflected the preoccupation with drugs in the outside community. Problems such as drugs and HIV/AIDS however, appear to be subject to time lags or delays before they manifest themselves within the prison environment. This is linked to the initial denial of the problems and the speed at which the Prison Service deals with issues. Once the Prison Service acknowledged the drug problem, they were forced to 'catch up' in their response to it. A director of a drug agency recalled that this was a slow process:

There was sort of a 'catch-up' phase where prisons themselves hadn't recognised that they had an issue around drugs and they had a very steep learning curve to navigate...It wasn't a problem they wanted to believe they had. How they might respond to it and what the resource implications of responding to it might be - that was a slow process.²⁸

²⁷Interview (021) with spokesperson for professional association, January 1998

²⁸Interview (028) with director of drug agency, January 1998

The response to the 'problem' of drug misuse in prison

The period from the late 1980s to 1993 was described as a time when a 'mood was developing' in terms of responding to the drug problem in prisons.²⁹ More formal and explicit policy development began with the statement of policy on the throughcare of drug misusers in prison in 1987 which carried through some of the issues which had been highlighted by the policy network which had formed around treatment and throughcare issues during the earlier phase. This was followed by a more comprehensive manual of policy guidelines entitled *Caring for Drug Users* in 1991. The HIV/AIDS crisis also resulted in policy development which intersected with prisons drugs policy. In the next sections, I will first explore the policy response to drugs and then discuss the response to HIV/AIDS.

Treatment and throughcare policy

Policy statement on the throughcare of drug misusers in prisons 1987

Following the interest generated by the ACMD and the policy network around throughcare issues during the early 1980s, an attempt was made by the Prison Service to issue a policy on this aspect of the prison drug problem. In 1987, a statement of policy and associated guidelines on the throughcare of drug misusers in prison was issued by the Director of Prison Medical Services to all managing medical officers (HM Prison Service, 1987). The focus was on the interface between the Prison Medical Service and the Probation Service. Although there was recognition that all prison staff could play a role in the throughcare, the statement advocated a more co-ordinated approach particularly between prison medical officers and seconded prison probation officers. The content of the statement did not focus on specific goals of the Prison Service in relation to throughcare, but was mainly concerned with loose guidelines regarding throughcare

²⁹Interview (030) with director of drug agency, February 1998

practice and specifying the responsibilities of the key actors involved. Prison governors were given overall responsibility for ensuring that a coherent system was established to deal with drug misusers. Medical officers were given responsibility for identifying and assessing drug misusers on reception to custody; arranging withdrawal programmes in accordance with their own clinical judgement; maintaining medical oversight throughout the prisoner's sentence; and advising on further drug treatment support through outside agencies or self-help groups. Prison probation officers were responsible for continuing care and support throughout prisoners' sentences, overall throughcare, and follow-up treatment and support on release. The medical officer and probation officer were to develop an effective working relationship and endeavour to communicate and liaise effectively over the care and support of drug misusing prisoners (HM Prison Service, 1987).

In practice, however, these throughcare guidelines were not fully implemented across the prison system. In a study conducted by National Association of Probation Officers (NAPO), probation officers indicated that the guidelines had not been acted upon and the inertia came from prison governors (Fletcher, 1990). The ACMD (1988: 63) found that the use of methadone and other drugs to alleviate withdrawal symptoms varied between prisons. Since the 1980 ACMD report, there was no evidence of any improvements in relation to drugs advice and counselling or the expansion of therapeutic programmes in prisons. Furthermore, voluntary agencies were still experiencing difficulties gaining access to undertake drug work in some prisons (ACMD, 1988: 63). Although the guidelines on throughcare placed great emphasis on the work of the probation service, there was evidence of seconded prison probation officers having very limited resources, experience and training to deal with drug misusers (ACMD, 1988: 63).

Policy on treatment: Caring for Drug Misusers 1991

In 1991, a manual entitled, *Caring for Drug Users*, was prepared by the Advisory Group for Drug Education, a multi-disciplinary group of experts from the Prison Service and

external drug agencies and organisations.³⁰ There was growing recognition of the variations in service provision throughout the prison system and that any effective drug work was 'locally inspired and led' (HM Prison Service, 1991a: 2). The aim of policy was to build upon these efforts across the Prison Service and to make the most of 'the opportunity presented by imprisonment to help drug misusers break or modify their habit' (HM Prison Service, 1991a: 2). The manual covered several issues in relation to caring for drug misusers in the prison system including guidelines for their assessment and identification, detoxification, treatment and counselling, general health care and lifestyles, harm minimisation, throughcare, and liaison with community agencies. A multi-disciplinary response was advocated which involved all prison staff including prison medical officers, probation officers, prison officers, psychologists, education officers, governors as well as specialist groups and agencies in the community. The aim was to create a positive climate in which drug users would reveal their drug problems and seek help.

Under these new guidelines, it was clear however that the quality and type of care for drug misusing prisoners was not congruent with what they would have received in the community. The legacy of the Rolleston report and the discourse of less eligibility in relation to the treatment of drug misusers in the prison system endured. Ross et al (1994), a group of solicitors, barristers, general practitioners and clinical psychologists, argued that the 1991 guidelines for dealing with drug misusers in custody breached normal standards of professional ethical care. For example, drug addicts in prison were much less likely to be receiving treatment with a notifiable drug (ie. methadone) than their counterparts in the community. In many cases, prisoners receiving methadone treatment on the outside were not given the opportunity to continue their treatment within prisons. Where methadone was offered in prison, it was provided on an accelerated seven day regimen³¹ (HM Prison Service, 1991, section 2: 4). The

³⁰ The Advisory Group for Drug Education was chaired by Dr Rosemary Wool, the Director of Prison Medical Services. It was comprised of representatives of the Directorate of Prison Medical Services, probation services, SCODA, ISDD, Parole Release Scheme, and the Drug Dependence Clinical Research and Development Unit at Bethlem Royal Hospital.

³¹ The only exceptions were HIV positive prisoners and pregnant women who could be offered longer methadone detoxification programmes.

accelerated withdrawal programme does not replicate the physiological rate of withdrawal and can cause withdrawal symptoms and stress to patients (Ross et al, 1994). Moreover, strip cells were often used for prisoners who were addicted to opiates. Such short regimens and harsh treatment may lead prisoners to use illegal drugs in prisons. Ross et al (1994: 1094) argued that the monopoly which the PMS had over medical provision in prisons, the non-standard treatment regimens and the abuse of the concept of clinical judgement left 'the prisoners disenfranchised to the point of suffering serious avoidable morbidity'.

At the same time as the manual was published, revised throughcare guidelines were also issued (HM Prison Service, 1991b). Re-emphasising the key roles of the probation service and prison medical officers, these were similar to those issued in 1987, but they placed much more emphasis on utilising a multi-disciplinary approach involving all prison staff. As discussed in the earlier section on partnerships in drugs policy, prisons were also encouraged to become involved in wider drug partnerships in the community. In 1988, a letter was sent by the Prison Service to all prison governors encouraging them to contact their local DDACs. Prisons were expected to be represented on DDACs where appropriate so that prisons could access local multi-disciplinary staff training provision and develop contacts with the providers of services (HM Prison Service, 1991a, Appendix 2).

Despite the key roles allocated to prison probation officers and prison medical officers, the HM Inspectorate of Probation found that prison probation officers were offering very little and prison medical officers were playing only a marginal role in the provision of drug services (Home Office, 1993). In prisons where drug work was occurring, outside drug agencies were playing the leading role in responding to the needs of drugs misusing prisoners. A director from a drug agency suggested that by the early 1990s, a UK model of prison drug work had emerged. This referred to the work being done by the Exeter Drugs Project in the Southwest, the Parole Release Scheme in the Southeast, and the York Drugs Resource Scheme in Yorkshire (see Parole Release Scheme, 1989; Tamlyn and Billings, 1995; Hamer, 1998). The model was described by a director of a drug agency as follows:

Each of these programmes developed independently, but when we did come together and talked about it, we realised we were doing the same thing. We were putting a large amount of emphasis on pre-release work with particular concerns regarding tolerance and overdose...We then got caught up in the HIV/AIDS scare....There was a fair amount of groupwork. The model for counselling was very much around brief interventions...There was an underlying consensus that prison wasn't the best place to deal with your underlying problems which may have precipitated drug use, but it may be the place where you start that journey and recognise how long the journey is and where you can go to complete that. The model used by all those agencies was about very high turnover and fairly brief work, trying to reach as many people as possible.³²

This model of drug work however was not universally applied throughout the prison system. It existed only in a few areas in the country and depended on the innovative work of particular drug agencies, rather than any centrally driven policy. As Roger Ralli, the Deputy Chair of the Advisory Group for Drug Education, conceded, in order for the 1991 guidelines to be put into practice across the prison system, there was a need for extensive staff training and support and commitment from prison governors (Ralli, 1994). In prisons where this guidance was implemented, the quality of services to drug misusers improved. However, the ACMD (1996) found that implementation was patchy and not all prison staff were aware of the existence of the manual. There was no centrally co-ordinated activity or provision. Similarly, the HM Inspectorate of Probation found that drug service provision was very ad hoc, piecemeal, and disorganised and there was a lack of an overall drugs strategy in prisons (Home Office, 1993: 75).

It is interesting to note that at this point in time security measures to tackle drug smuggling, drug trafficking and drug use in prisons were dealt with separately under security policies. There was no overall policy or strategy which connected drug control measures with treatment and throughcare measures. The focus was solely on the treatment and 'caring' aspects of dealing with drugs. This was to change significantly in later prison drugs policy development from 1994 onwards. In effect, the response during this phase was essentially about the Prison Service reluctantly acknowledging the problem of drug misuse in prisons, but not initiating any action which would embarrass

³²Interview(026a) with director of drug agency, January 1998

them or lead to public disapproval.³³ It was an attempt to address some of the problems highlighted by the policy network around treatment and throughcare and some of the criticisms outlined in the Woolf report. However, it was not a integrated strategy which would address the drug problem in prisons holistically.

The next section will outline the response to HIV/AIDS during 1986-1993 which intersects with drugs policy development in prisons.

Managing and containing the HIV/AIDS crisis in prisons

The majority of prison staff and prisoners reacted with fear, panic and antagonism towards the first group of known HIV positive prisoners (HM Prison Service, 1995). The panic around the disease was magnified within the prison environment shifting the focus of the problem from one that was seen to be primarily medical to a management problem for the Prison Service. A civil servant recalled this shift:

It was the reaction of the staff to them that made it quite clear that this was something that had to be dealt with. Up to that point, people assumed that it could be dealt with in a reasonable way as a medical concern. It was only when staff reaction became so vivid, that in fact, it was realised that it wasn't just a medical problem, but that it was a management problem.³⁴

In 1986, the prison chaplain at Chelmsford died of an AIDS-related illness and his death sparked off industrial action by prison staff. As discussed in the previous section on penal policy, industrial relations between the Prison Officers' Association (POA) and prison management continued to be fraught with difficulty during this period due to the introduction of Fresh Start in 1987. It was within this context that at the AGM of the POA in 1987, a resolution was passed which called for the compulsory screening of all prisoners for HIV. It was argued that this would enable prison officers to protect

³³Interview (030) with director of drug agency, February 1998

³⁴Interview (031) with civil servant, March 1998

themselves from the virus if they knew which prisoners were HIV positive. However, the then Director of the Prison Medical Service, Dr John Kilgour, decided against compulsory screening and maintained that any HIV testing should be voluntary, carried out only with the prisoner's consent, and with the provision of pre- and post-test counselling. Because many of the management decisions had been devolved to local level, there was evidence and rumour that screening was nevertheless taking place in some prisons (Berridge, 1996a). Similarly, Turnbull et al (1991) found that some 'high-risk' groups, including drug users, were being segregated until they agreed to be tested and could prove they were negative.

Viral Infectivity Restrictions (VIR)

One of the methods of dealing with HIV positive prisoners was to subject them to Viral Infectivity Restrictions (VIR). These guidelines were originally developed in 1985 for prisoners with Hepatitis B to protect others within the institution from this highly contagious disease. The type of restrictions placed on infected prisoners was left to the discretion of the medical staff, but they could be segregated in a separate unit or isolated cells. Moreover, their regimes could also be restricted in terms of association with other prisoners and participation in work and recreation activities (HM Prison Service, 1995: 7). In May 1986, the Prison Service produced a confidentiality code for prisoners subject to VIR. In theory, this meant that prison staff with an operational 'need-to-know' were informed of a prisoner's VIR status, while the actual diagnosis (ie. HIV or Hepatitis B) remained confidential. However, the definition of 'need-to-know' remained vague and in practice, confidentiality was not preserved (Padel, 1990). In some cases, VIR status was stamped on prisoner's files and the code was also extended to those outside the prison including court staff, police and others involved in the criminal justice system (Prison Reform Trust, 1988). Due to the fear and panic amongst prison staff and other prisoners, VIR status became synonymous with HIV (Bright, 1995). The effect of VIR and the lack of confidentiality meant that prisoners feared revealing that they belonged to a high-risk group (ie. drug misusers, prostitutes, homosexuals or haemophiliacs) due to the treatment they might receive. A drug worker recalled the

difficulties in providing drug services in prisons at this time:

We had horrendous difficulties if we had an HIV person and it became widespread public knowledge in the mid to late 1980s...There was a lot of ignorance around - a lot of fear...There was pressure at that time to disclose if someone had revealed an HIV status or even if they revealed they were [in] a high-risk group....The way they identified HIV inmates was to put yellow and red tape around their files...And of course, that would be in the landing office and many people got badly hurt when their status became known amongst the other inmates.³⁵

There had been several calls to end the use of VIR by various experts and organisations (WHO, 1987; ACMD, 1988;1989; Farrell and Strang, 1991; Woolf and Tumin, 1991). By 1991, the Prison Service recommended that HIV positive prisoners who were otherwise healthy should not be segregated, but kept on normal landings. However, medical officers and prison management retained the power to segregate HIV positive prisoners 'for reasons of good order, discipline, health or safety' (Home Office, 1991a, annex A, para 18). The application of this policy was strongly localised (Berridge, 1996a). For example, on the K1 wing of Wandsworth prison, VIR and segregation still operated and prisoners were kept in a basement with little time out of their cells, whereas Bristol prison had rejected VIR, ensured full confidentiality to HIV positive prisoners and integrated them on normal landings. The practices at Wandsworth prison had been condemned in 1991 by the Woolf Inquiry as a 'travesty of justice' (Woolf and Tumin, 1991: para 360). Although there had been many calls for reform in relation to VIR, one third of prisons in England and Wales were still segregating HIV positive prisoners (ACMD, 1993). The manner in which HIV positive prisoners were dealt with in the prison system illustrates the Prison Service's preoccupation in dealing with high-risk groups rather than tackling high-risk behaviour.

By 1986, the Prison Service had established an AIDS Advisory Committee to advise the Director of Health Care on all matters relating to HIV in prison. Its membership included outside agencies, independent experts on HIV and prison staff. The

³⁵Interview (006) with drug agency worker, October 1997

Committee developed a strategy which aimed to: prevent people from becoming infected; prevent onward transmission of the virus; minimise the social stigma of HIV and provide proper medical treatment, support and care to those with HIV (HM Prison Service, 1995c: 10).

Training and education

Prisoners were excluded from the general public education effort on HIV which took place in the community, leaving them with little factual information about the virus. When the leaflets entitled, 'AIDS - Don't die of ignorance' were distributed to every household in the country, prisons and hospitals were not included in the initial distribution. Parliamentary questions were tabled regarding this matter and eventually the leaflets were made available (Prison Reform Trust, 1988). However, this information did not address the specific concerns of prisoners. In August 1987, a leaflet was specifically designed for prisoners entitled, 'AIDS: Information for People in Prison'. Because drug injecting and homosexual sex contravene prison rules, these issues were not addressed adequately in the leaflets and distribution to all prisons and prisoners did not occur (ACMD, 1988; Prison Reform Trust, 1988).

Prison was still being regarded as an 'opportunity' to make contact with drug misusers, draw them into treatment and educate them towards safer practices (ACMD, 1988). Education and training were regarded as the cornerstones of the Prison Service's response to the HIV/AIDS problem in prisons (HM Prison Service, 1995c: 21). In 1987, the AIDS Advisory Committee developed, 'AIDS Inside', a training package for prison staff consisting of a video, leaflet and training manual. In 1989, a similar package entitled, 'AIDS: Inside and Out' was developed for prisoners. These training and educational efforts had limited impact however (Turnbull et al, 1994; Berridge, 1996a) and targets for the education of operational staff and inmates had not been achieved in many institutions (Curran, 1991b). Trace (1990) argued that few staff were interested in HIV training sessions and for those who were interested, it was difficult for them to watch the videos due to other duties. The video for prisoners explored what was

defined as 'risky behaviour', but failed to acknowledge that these activities actually occurred in prisons. In a section on how to protect yourself after release, the leaflet provided advice on safer sex and injecting practices (Trace, 1990). Thus, the focus was on activities on release, rather than those within prison. The ACMD (1988) recommended that private and confidential counselling should be provided on risk reduction covering activities both whilst in prison and on release. The ACMD felt it most appropriate that outside agencies undertake this work rather than prison medical officers. The educational package also failed to address the needs of women, young people, those without English as their first language and those with learning difficulties. The Prison Service however did not view this as a matter for concern and recommended that these particular groups could be dealt with at a local level (HM Prison Service, 1995c: 27).

In 1991, the Prison Service issued a circular instruction³⁶ indicating that all prisons should set up multi-disciplinary working arrangements to deal with HIV/AIDS (Home Office, 1991a). This was linked to a training manual, *HIV and AIDS: a multi-disciplinary approach in the prison environment*, and three specialist training courses. These training courses included an HIV update for medical officers, an HIV counselling course for prison staff, and a multi-disciplinary course for prison managers. The multi-disciplinary approach was to involve medical officers, psychologists, probation officers, health care staff, prison officers, educationalists, and the prison chaplaincy. Curran (1991b: 17) suggests that there were several factors which mitigated against such an approach and the implementation of the strategy: HIV was often viewed as a medical problem by operational managers and staff; there were several competing priorities within the prison system and a large number of new initiatives (ie. Fresh Start, Prison Service re-organisation, suicide prevention, and sex offender programmes); there was a lack of good information regarding prevalence of HIV and risk behaviour; and the numbers of prisoners known to be HIV positive was low.

³⁶ This is an instruction issued by Prison Service Headquarters to all governors of prisons.

As discussed earlier, the advent of HIV/AIDS in the community was eventually followed by an expansion of services for drug misusers, the adoption of the principles of risk reduction and harm minimisation, and a broad-based community approach involving doctors, pharmacists, police, social workers, and probation officers. However, prisons were excluded from these changes in practice and the liberal consensus which had been achieved (Farrell and Strang, 1991; Berridge 1996a). The incorporation of harm minimisation as a drug treatment philosophy had been met with difficulties within the prison environment resulting in inadequate choice and standards of care in relation to HIV positive prisoners compared to similar patients in the community (Young and McHale, 1992). One of the main factors in the adoption of the 'abstinence' based approach was the resistance to publicly acknowledging that either drug taking or homosexual sex is taking place in prisons. To adopt a harm minimisation and risk reduction philosophy would mean condoning two illegal activities in the prison environment. This was seen by the Conservative government, in particular, to be politically unacceptable. The Home Office's reliance on 'legal formalism' placed prisoners at greater risk from HIV/AIDS than the general public (Thomas, 1990: 90).

In the area of prison drugs policy, it is evident that the 'conflict between principle and pragmatism is most acute.' (MacGregor, 1998a: 149). Traditionally, the criminal justice system has viewed drugs as a cause of criminality and a crime in itself, not as an individual health or public health concern. This criminal justice perspective towards the control and criminalisation of drug users has constrained prison governors and others from incorporating harm minimisation into drug policies (Hayes, 1991). The definition of harm minimisation in prisons was described by a civil servant as being different to that in the community:

...We probably still encounter a little lack of clarity by what we mean by harm minimisation. Because on the streets, [it] means needle exchanges and things like that. Now we know we're not going in the foreseeable future down the route of needle exchange.³⁷

³⁷ Interview (019) with civil servant, December 1997

Within the prison environment, the definition of harm minimisation could be extended to include more than just safe injecting practices, safe sex and methadone prescribing. Similar to Pearson's arguments that the principles of harm reduction should have wider application, (Pearson, 1992b), a civil servant argued that in practice the term needed to be associated with providing a safe environment for prisoners in terms of the violence and bullying around the drugs trade:

Harm reduction is also about going back to the violence thing [and] is linked to helping prisoners, particularly young offenders, get through their sentence safely...Many governors [who] are aware will not say, 'don't take drugs because they'll harm you', because they realise that's not going to have impact on recreational users. What they will probably say is, 'For goodness sakes, don't borrow money to buy drugs. That's the real danger'.³⁸

In the community, policies have vigorously promoted safe sex practices and the use of condoms in the prevention of HIV. The Prison Service, however, initially resisted the introduction of condoms mainly on legal grounds. Under the Sexual Offences Act 1956 (as amended in 1967 and again in 1994), homosexual sex is considered legal only if it occurs in a private place between two consenting men aged eighteen or over. It is legally unclear whether a prison cell constitutes a private place as required by the Act. If a cell is not private then homosexual activity is unlawful. This issue has been the focus of much debate between the Prison Service and its legal advisers.³⁹ The Prison Service has argued that the provision of condoms would mean that illegal acts were being condoned. However, the ACMD (1988: 65) pointed out that it was difficult 'to see how allowing access to condoms in prison could be regarded as condoning unlawful acts when placed in the context of the public health considerations involved.' Other arguments were also made by the Prison Service that condoms do not provide adequate protection in anal sex; condoms would increase the incidence of homosexual activity; there was a lack of evidence that high-risk behaviour occurs; staff would object; and condoms could be used

³⁸Interview (014b) with civil servant, November 1997

³⁹Interview (001) with civil servant, September 1997

for other purposes such as drug smuggling (Curran, 1991c).

In other European prison systems, including France, Denmark, Germany, and the Netherlands, condoms have been made available to prisoners (British Medical Journal, 1995). There have been various calls from outside bodies and organisations for the provision of condoms in prison (WHO, 1987; ACMD, 1988;1989; Trace, 1990; Prison Reform Trust, 1991). Curran and Morrissey (1989) also found that the majority of prisoners and staff at Wormwood Scrubs wished to see condoms provided. Based on the House of Lords judgement in *Gillick v West Norfolk*, if prison medical officers were providing the means of protection, they could not be held responsible for encouraging an illegal act. In effect, the provision of condoms in prisons was seen to be a medical matter. Therefore during the period 1986-1993, the prison policy on condoms was that they could be provided subject to the clinical judgement of the prison medical officer. In practice, however, condoms were not freely available as many prison medical officers refused to view them as a prescription and prisoners were reluctant to request them.⁴⁰

Similar to the issue of condoms, the provision of needle exchanges in prison has not been seen as appropriate by the Prison Service (HM Prison Service, 1995) or by the ACMD (ACMD, 1988). Needle exchanges could be seen as encouraging drugs use and contradictory to the duties of prison staff to detect the smuggling of drugs into prisons and prevent drug misuse in custody. It was felt that 'the conflict between encouraging prisoners to use an exchange scheme and detecting illicit drug use would have no easy resolution' (HM Prison Service, 1995: 30). Arguments have also been put forward that needles could be used as weapons within the prison environment (Trace, 1990; British Medical Journal, 1995). However, stopping syringes and drugs getting into prisons means that there will be more sharing of existing ones and thus, a greater threat of HIV transmission.

Because the Prison Service adopted an abstinence-based approach to drug misuse, this set the scene for conflict between the prison administration and the drug agencies who

⁴⁰ Interview (026a) with director of drug agency, January 1998

may be working within a harm minimisation framework. There are clear conflicts and contradictions within drug work in the prison environment which are contained and managed by the drug agencies involved. A civil servant indicated the difficulties from their perspective:

It's a hard one for us in working with the agencies who quite properly would talk about harm minimisation approaches. It's hard for us to say that means that some of our prisoners are taking drugs some of the time because it's an illegal activity that we have some difficulty in countenancing. It's a rubbing point between work agencies can do and our approaches to it. Sometimes those things don't come together very neatly.⁴¹

However, drug workers have been forced to find ways of delivering realistic strategies within the prison environment:

We can actually work with harm reduction providing we're working towards providing an abstinence-based regime. You can get away with it...The people on the ground are realists. They know that they need something being done.⁴²

Obviously we were worried about needle sharing in prisons and addressing that through harm reduction techniques...There was a tacit condoning by the Prison Service that they intentionally would not be in the room when we were talking about harm reduction.⁴³

These contradictions between policy and practice have allowed the Prison Service to publicly advocate a tough, abstinence based policy towards drugs, while drug agencies are working behind the scenes in the privacy of the prison ensuring harm minimisation is taking place without the support of the institution, adequate resources or an 'official' policy framework. The Prison Service has been reviewing its policies on risk reduction and harm minimisation for many years. Issues such as the availability of sterilising tablets and condoms have been debated frequently, but some of the decisions or compromises which have been reached have not been satisfactory and have placed prisoners at greater risk of infection. In response to the recommendation made in the Woolf report and to

⁴¹ Interview (014a) with civil servant, November 1997

⁴² Interview (010) with director of drug agency, November 1997

⁴³ Interview (026a) with director of drug agency, November 1997

concerns expressed by Judge Tumin regarding the treatment of HIV positive prisoners, the Prison Service AIDS Advisory Committee undertook a policy review⁴⁴ of HIV/AIDS in prison which began in 1992. It was not until 1995 that the Committee published its review and its recommendations. These will be discussed in the next chapter.

It is evident that many of the ideas and discourses which were prominent in drugs policy during the 1986-1993 period failed to penetrate the development of drugs and HIV/AIDS policies in prisons. The policies which did emerge, including the 1987 throughcare guidelines, 1991 treatment manual, and HIV policies on VIR and education and training, were hindered by implementation which was strongly localised. The Prison Service limits its role to setting a policy framework and standards and then local management applies these to mirror local circumstances. Although the Prison Service can highlight the importance of the policy guidelines and their recommendations for good practice, they have no power to ensure that these are implemented locally. This allows for much discretion and choice, particularly for prison governors, in implementing central policy decisions often leading to wide variation and lack of consistency across the system.

Conclusion

During the phase 1986-1993, the HIV/AIDS crisis became the driving force behind the development of a more explicit prison drugs policy. By 1986, the HIV/AIDS issue had become linked to injecting drug misuse and fears of transmission into the heterosexual population became a reality. In the community, HIV/AIDS had become a 'national emergency' in policy terms provoking a 'wartime response' (Berridge, 1996a). Prisons were no longer immune from external scrutiny and could not deny the existence of the drug problem in prison. The 'official' discourses around drugs in prison which were

⁴⁴ The Committee's brief for the review was to review the progress of the Prison Service strategy so far and to consider how this should be developed in order to prevent the spread of HIV infection in prisons, provide for the health and safety of staff and prisoners and to consider what services would be required to provide a standard of care to prisoners with HIV infection equivalent to that in the community (HM Prison Service, 1995c: 4).

evident in the early 1980s could no longer be sustained. The 'end of the denial' was linked mainly to the HIV/AIDS issue, but also to a growing evidence base which began to challenge the view that a drug problem did not exist in prisons. Furthermore, a policy network was growing around the drugs and HIV issue in prison which began to lobby the Prison Service for a humane and pragmatic response.

Although a liberal response to the issue of HIV/AIDS and drug misuse had eventually been achieved in the community through policies of harm minimisation and risk reduction, this was extremely difficult to extend to the prison environment (Berridge, 1996a). Such policies were constrained by the institutional context of the prison system and the unwillingness of the Prison Service to consider radical policies. The inherent conflict between care and control and concern about the public imagery of adopting anything other than a hard-line, abstinence-based approach was important during this period and became enduring features of subsequent policy development. The focus of the next chapter is the period 1993-1997 in which fundamental changes occurred within drugs and penal policy and most importantly, prison drugs policy.

Chapter Five

1993-1997: Coming clean and taking control?

Introduction

In this chapter, I will focus on the period 1993 to 1997 in which significant developments took place in prison drugs policy. This phase begins in 1993 because this year marked a dramatic U-turn in penal policy which greatly influenced the development of drugs policy in prisons. By 1995, the first prison drugs strategy was formulated involving an explicit and comprehensive plan to tackle and measure the drug problem in prisons. In contrast to the earlier phases of policy development, the new strategy incorporated both supply and demand reduction measures. It introduced new powers to test prisoners for drugs, increased security measures and emphasised drug treatment and rehabilitation. For the first time, prison issues were incorporated into national drugs policy and the Prison Service was expected to play a key role in national and local drugs policies and partnerships.

In order to contextualise the changes which took place in prison drugs policy during this period, I discuss the key developments in drugs and penal policy in the first part of the chapter. These changes were occurring against the backdrop of the Major government which continued and intensified Thatcher's key reforms. A new 'Back to Basics' campaign was introduced which reaffirmed traditional Conservative themes such as the nuclear family, law and order, discipline and educational standards. By the mid-1990s, the Conservative government had implemented a range of legislation which increased the state's power to intervene in the lives of those on the political and economic margins or the so-called 'problematic' groups such as single parents, young people, the homeless, drug takers, illegal immigrants, and the unemployed (Ryan and Sim, 1995). With regard to offenders, Major argued that 'we should understand less and condemn more' (quoted in Downes and Morgan, 1997: 130). During this phase, both penal and drugs policy were affected by the populist punitive rhetoric and by the new managerialism which had

effectively penetrated both policy areas. The national drugs strategy, *Tackling Drugs Together*, marked a retreat from the principles of 'harm minimisation' of the previous phase of policy, a move towards the discourses of 'enforcement', 'control' and 'punishment', and a greater emphasis on criminal justice involvement in drug issues. Moreover, the new drugs strategy indicated a shift towards a more 'managerial' discourse around drugs, emphasising performance measurement, action plans, partnership, and co-ordination at all levels. Similar developments had been occurring in penal policy when the Prison Service became an agency in 1993. During 1993-1997, penal policy was subject to a complete reversal. The discourses of 'just deserts', 'prison makes bad people worse' and 'punishment in the community' of the late 1980s and early 1990s were replaced by the discourses of 'prison works', 'austerity', and 'law and order' which were advocated by the new Home Secretary, Michael Howard. These emerging drug and penal policy frameworks underpinned the development of prison drugs policy.

The latter part of the chapter explores the way in which the drugs 'problem' was framed by key players and the policy response. During this phase, the drug issue in prisons was officially acknowledged and politicians in a sense had 'come clean' regarding the 'problem'. Drugs were increasingly framed as a 'problem' of order and control for the institution. The response in both political and policy terms was to 'get tough' and take control of the problem by implementing a defined strategy which emphasised mandatory drug testing and security measures. As prison drugs policy became more explicit, the contradiction between treatment and punishment intensified. A number of competing objectives required balancing: safety, security, control, punishment, treatment, and care. However, the policy framework failed to address how the 'balancing act' could be achieved (Seddon, 1996). It was unclear in its presentation 'whether the medical approach [was] incorporating the penal, or vice-versa'; however it was clear that the tensions and convergences between medical and penal forms of control were once more on the agenda (Berridge, 1996b: 304). Within a framework which included a punitive political context, an increasing emphasis on managerialism and the influence of US policies and ideas, this chapter will show that the penal aims of the strategy had clearly taken precedence over those of health and treatment. In response, a policy network began to form which criticised the introduction of mandatory drug testing and the over-

emphasis on control and punishment. It lobbied for increased resources and more focus for treatment and care. Although this network had some success in rebalancing the strategy, the focus on punishment, control and security continued to be predominant.

Drugs policy context: Tackling Drugs Together (TDT)

During the period 1993 to 1997, official statistics indicated that the drugs ‘problem’ in the community was continuing to grow. For example, the number of new drug addicts notified to the Home Office increased steadily from 11,561 in 1993 to 18,281 in 1996 and the proportion addicted to heroin increased by six per cent during this period (see Table A.3, Appendix A). The number of persons found guilty, cautioned or dealt with by compounding for drugs offences also increased dramatically from 68,480 in 1993 to 113,154 in 1997 (see Table A.2, Appendix A). By the early 1990s, the drug problem in Britain had changed. Research began to show that poly-drug use including cannabis, amphetamines, LSD, and Ecstasy was increasing amongst young people (see Denham-Wright and Pearl, 1995; Miller and Plant, 1996; Parker et al, 1998; Shiner and Newburn, 1999). A poly-drug culture had developed where a ‘hedonistic smorgasbord’ of drugs was available (South, 1997: 930). Howard Parker and his colleagues (1998) describe this trend as a process of ‘normalisation’ whereby recreational drug taking is incorporated into lifestyles which are otherwise conforming. Other commentators such as Shiner and Newburn (1999) have challenged the idea of normalisation and argue that both the extent and context of youth drug use have been exaggerated. They claim these accounts are inaccurate based on their interpretations of the evidence. Their analyses show that young people have continued to express restrictive attitudes towards illegal drugs and drug misusers. The debate has not been settled. However, it is clear that if a process of normalisation is occurring, this has great significance for drugs laws and policy and the planning and providing of services (South, 1997: 930).

In 1994, the government’s newly proposed drugs strategy was published as a Green Paper, *Tackling Drugs Together*, and disseminated widely for consultation. Over four hundred organisations and individuals submitted comments and evidence to the Central

Drugs Co-ordination Unit (HM Government, 1995: 53). In May 1995, the strategy was revised and published as a White Paper, outlining the government's plans for tackling drugs for the period 1995-98. This represented the first attempt to provide a national drug 'strategy' as previous frameworks tended to be more descriptive of current policy (ie. the 1990 document, *UK Action on Drug Misuse*), rather than strategic (Dorn and Seddon, 1995). The strategy focused on three main areas: crime, young people and public health. It was underpinned by the following common Statement of Purpose:

To take effective action by vigorous law enforcement, accessible treatment and a new emphasis on education and prevention to: increase the safety of communities from drug-related crime; reduce the acceptability and availability of drugs to young people; and reduce the health risks and other damage related to drug misuse (HM Government, 1995: 1).

As was the case in other policy areas, the strategy also introduced performance indicators to monitor and evaluate progress, indicating a more 'managerial' approach towards the problem of drugs. The new strategy represented a new conception of what constituted 'policy'. It was much more strategic, concrete and specific in relation to key aims and objectives than previous policy frameworks. A civil servant described the differences between the 1995 strategy and past attempts:

It was the first time we had a specific and detailed action plan, guiding activities over a finite period with specific tasks, objectives, and some very rough and ready KPI's¹ - but certainly an attempt to measure where we were going and what we were doing. It was in a detailed document that everyone shared along with the Statement of Purpose...Whereas in the past, the strategy was little more than an exaltation that people wheeled out from time to time when it suited them. Departments, by and large, went about their business on their own...It was a bit of a gentleman's club type approach...Well, we'll have a 5 point strategy, reducing the supply of drugs because it will reduce the demand. The Home Office will do this, the DoH will do that, we'll have a Ministerial Group. But it was just fuzzy and it didn't mean anything, until we got a much harder-edged, in the government's terms, 'business type' approach to all this. And things needed

¹ KPIs refer to key performance indicators which 'involve deploying data to allow normative judgements of the 'product' of public sector service providers' (Cutler and Waine, 1997: 32). See Chapter Two of Cutler and Waine (1997) for a more detailed discussion of the definitional issues, the political context, and the methodological and conceptual problems involved in performance measurement.

*to be brought together and co-ordinated in a proper way.*²

The strategy, however, focused almost exclusively on drugs and the drug problem and failed to make links between drugs and other social issues such as housing, employment and economic regeneration. The three strands of the Statement of Purpose were to be interdependent and given equal importance. Although both the Green and White Papers stressed that the Statement was not listed in priority order, the order has been assumed by informed observers to reflect the priorities of the strategy. Many groups, associations and individuals responding to the original Green Paper argued that a careful balancing act would have to be achieved to ensure that crime, enforcement and control objectives would not override public health, treatment and prevention objectives (see ACOP, 1995; ACPO, 1995; ADSS, 1995; All Party Drugs Misuse Group, 1995; Baroness Jay of Paddington, 1995; LDPF, 1995; LGDF, 1995; Phoenix House, 1995; Release, 1995; SCODA, 1995; Turning Point, 1995). The strategy also represented a retreat from the harm minimisation principles which had been pursued during the previous phase of drugs policy from 1986 to 1993 (Ashton, 1995). Abstinence had now become the goal of intervention with harm minimisation as a means to that end, rather than an end in itself (HM Government, 1995). During this phase of policy development, it appeared that concern around HIV/AIDS was superseded by the relationship between drug misuse and crime. The 'drugs-crime link' had become the driving force behind policy development. Further research on the links between drugs and crime was to be commissioned by the Home Office (HM Government, 1994). Moreover, the criminal justice system was increasingly being seen as a location or opportunity for drug treatment intervention. Findings from the National Treatment Outcome Research Study (NTORS)³ showed that the 1,110 drug misusers in the NTORS cohort had committed over 70,000 separate crimes in the three months before entry into treatment. In the two years prior to

² Interview (012) with civil servant, November 1997

³ In 1994, an independent task force was established by Ministers to examine the clinical, operational, and cost-effectiveness of existing services for drug misusers. As part of their review, the Effectiveness Review Task Force commissioned the National Treatment Outcome Research Study (NTORS). This study began in 1996 and tracks 1,100 drug misusers for a five year period from the point at which they enter treatment. Data will be provided on four treatment modalities: methadone maintenance, methadone reduction, residential rehabilitation and specialist in-patient drug dependence units (ISDD, 1996: 26)

treatment, the cost to the criminal justice system in dealing with their offences was estimated at £4 million and the cost to their victims was estimated at £34 million (Department of Health, 1996: 11)

The emphasis on enforcement-related activities was also reflected in the amount of resources spent on each activity. The funds spent on enforcement, deterrence and controls greatly outweighed those spent on treatment, rehabilitation, prevention and education. For example, for the year 1993-94, the government spent an estimated total of £526 million on tackling drug misuse across the UK with £209 million being spent on police/customs enforcement, £137 million on deterrence and controls, £104 million on prevention and education, £61 million on treatment and rehabilitation and £15 million on international action (HM Government, 1995, annex B). The new strategy did not attempt to overhaul radically or redistribute drug spending. Very few new resources were made available.⁴ Informed members of the drugs policy community suggested that the national drugs strategy was imbalanced and focused too much on enforcement issues. They thought the claim that the three strands of the Statement of Purpose (ie crime, young people, and public health) were to be given equal importance was meaningless rhetoric. The only way to rectify the imbalance in practice would be to radically overhaul drugs spending. On the other hand, a civil servant argued that one of the reasons the national drugs strategy was successful was precisely because it did *not* attempt to redress the balance:

*Addressing these problems between health and enforcement - that's really difficult to do. The reason TDT was so successful is that it didn't try to. It said things and put things together [but] didn't actually try to confront what might be seen as difficulties and differences...The only way you can get over them is by pushing things locally.*⁵

The bifurcation in drugs policy described in previous chapters continued to operate

⁴In 1995-96, £5.9 million was made available for drugs education in schools, £1 million for the development of early intervention schemes for young people and £4.6 million for mandatory drug testing and treatment in prisons. Over the course of the three year strategy, an additional £8.8 million was also made available for the development of Drug Action Teams (HM Government, 1995).

⁵Interview (007) with civil servant, October 1997

during this later phase of policy development. The emphasis was on prevention and education for young people and treatment for the 'deserving' victims of drugs, with increased enforcement and policing for the hardened user who might also be offending. Under the aim 'to increase the safety of communities from drug-related crime', one of the main objectives was 'to reduce the level of drug misuse in prisons'. This was the first time that penal drugs policy objectives had been systematically incorporated at the national level. Due to the growing interest in drug issues in prison within policy networks throughout the 1980s and early 1990s (as well as the fact that law enforcement was one of the main planks of the strategy), the drugs policy community saw the inclusion of prisons in national policy development as imperative. However, some alluded to the fact that the Prison Service was reluctant to be incorporated into the new drugs strategy. This resistance reflected the insularity of the Prison Service and their tendency to work on their own with little outside input. As a drug agency director recalled:

My memory basically is that the Prison Service were trying to stay out of that. They were trying to plough a single furrow on their own. They felt that they had a problem and it was a 'prison' problem and they could deal with their 'prison' problem. It was with quite considerable reluctance and a great deal of political pressure that they became part of the targets within TDT. That demonstrates things which are evident in other organisational structures as well - structures that are very self-contained which see themselves to some degree as being afflicted and criticised. They felt at the point that they could produce some sort of solution which was just their solution which didn't go beyond their own walls. My sense at that time was that the Prison Service nationally came on board reluctantly.⁶

National and local co-ordination

The White Paper stressed that in order to achieve progress towards the aims and objectives, multi-agency co-ordination needed improvement at both national and local

⁶Interview (008) with director of drug agency, October 1997

levels. At the national level, co-ordination at Ministerial level remained with the Ministerial Sub-Committee on the Misuse of Drugs⁷, chaired by the Lord President of the Council. At official level, the Central Drugs Co-ordination Unit (CDCU) was established in 1994 to support the Lord President in co-ordinating the implementation of the drugs strategy and to ensure the policies and practice of the lead departments involved in tackling drug misuse were coherent. CDCU performed a liaison role, with the various departments each retaining control of their particular policies, operations and resources (HM Government, 1995). CDCU was part of the Privy Council Office and physically located in the Cabinet Office, rather than in any particular government department with an interest in drug issues. In many ways, this new structure at the heart of government represented a new 'neutrality' in drugs policy. The location also ensured that drug issues assumed a very high profile position within the hierarchy of government. The CDCU had helped to resolve some of the historical tension between the Home Office and the Department of Health over drug issues. As a civil servant commented:

*...CDCU has been instrumental in reducing those tensions...That's partly because the strategy sets out quite clearly what we are trying to achieve. The CDCU is a very useful focal point for discussions...The instrumental things are the CDCU and the fact that there is a strategy which really sets out what we're trying to achieve, rather than leaving us at the whim of Ministers.*⁸

However, others argued that although co-ordination had improved, departmental tensions still existed. These emanated from fundamental differences in their philosophies about what type of action should be undertaken around drug issues. As a civil servant argued:

We're working side by side, with better acknowledgement of what each other's doing, and better sharing of things, but we're still not engaged in any joint enterprise...The public health dimension is quite different from the

⁷ The Sub-Committee was comprised of Ministers from the following departments: Customs and Excise, Defence, Education, Foreign and Commonwealth Office, Health, Home Office, Law Officers, Scottish Office, Welsh Office, Environment and the Ministers for Overseas Development, Northern Ireland, and Employment are invited to attend as appropriate. The terms of reference were 'to coordinate the Government's national and international policies for tackling drug misuse, and report as necessary to the Ministerial Committee on Home and Social Affairs (HM Government, 1995: 4).

⁸ Interview (009) with civil servant, October 1997

*sort of point of view that the Home Office would have in terms of social problems...There's still a basic difference there.*⁹

At the local level, 105 Drug Action Teams (DATs) were established to deliver the strategy on the ground. As in other areas of social policy, there was a rediscovered emphasis on area-based policies to recognise diversity at a local level and allow for variation in response (MacGregor, 1998c). As we saw in the previous chapter, the previous partnership arrangements - DDACs - had not been working effectively. DDACs were replaced by the new DAT structures which were to be comprised of senior representatives from the police, probation and prison services, local authorities, including education and social services, and health authorities. Co-option of voluntary sector representation was also encouraged. Each Drug Action Team was expected to establish at least one Drug Reference Group (DRG) made up of individuals or groups in the community who had local knowledge, expertise, or experience in drug misuse. The new strategy also attempted to involve new groups in the policy-making process. DATs were encouraged to develop links with relevant regional bodies, particularly Home Office Drug Prevention Teams, Government Offices for the Regions, Area Justice Liaison Committees, other DATs around the country, local prisons and the private sector. Drug issues and policies were now seen to link more directly with other social processes, structures and policies (MacGregor, 1998c).

The role of the Teams was to make progress in terms of the overall aims and objectives of the national drugs strategy and adapt action to local circumstances.¹⁰ However, very little new money was made available for the development of DATs. In 1995/96, £16,000 was allocated to each district health authority and in 1996/97 and 1997/98, £33,000 was allocated. The starting point for the boundaries of Drug Action Teams was the district

⁹Interview (007) with civil servant, October 1997

¹⁰ DATs were expected to incorporate the following elements into their terms of reference: to assess the nature and scale of local drug problems and the effectiveness of current responses to them; to ensure that the strategies, policies and operations for tackling drug misuse of the organisations represented on the Team are in accord with each other; to ensure that a Drug Reference Group is established and operates effectively; and to ensure that appropriate action is identified and implemented to make progress in line with the Statement of Purpose and the national objectives of the White Paper, in the light of local circumstances and needs (HM Government, 1995:58).

health authority (DHA). Many respondents to the original Green Paper were opposed to DHAs as the boundaries for DATs and suggested that local authority boundaries would be more appropriate (see ACOP, 1995; ACPO, 1995; ADSS, 1995; LDPF, 1995; LGDF, 1995; Phoenix House, 1995; SCODA, 1995). For many agencies, including the police, probation and prisons, the DHA boundaries would cause significant problems in terms of sending representatives to a large number of DATs. These agencies would be unlikely to be able to send an appropriately informed and influential chief officer to sit on each DAT, thus draining the DAT of influence and credibility. There was also concern among those responding to the Green Paper that given the key role of health authorities in setting up the structures, health issues would dominate. Several agencies pointed out that local communities identify with local authorities rather than health authorities and that local authority boundaries are better established compared to DHAs which had been through much change and were not easily identifiable.

Prison representation on DATs and DRGs was considered to be very important, but as the ACMD (1996) warned there were several practical barriers to making this a reality. Firstly, prisons are situated in locations which do not match any neat structural map or set of boundaries. For example, some health authorities have more than one prison within their geographical boundary, while others have none. Secondly, the allocation of offenders to prisons is based on a number of factors with geography being only one. Therefore, health authority concern for prisoners from their district and interest in any prison within its area would often involve different populations. Thirdly, some prisons serve an area covered by several DATs. Attendance at each might be unrealistically demanding on a particular prison and might seem of little relevance to any particular DAT if prisoners from that district were housed not only in the local prison, but in others around the country (ACMD, 1996: 34-35). In addition to these practical barriers and perhaps more fundamentally, prison involvement on DATs could be hindered by the insularity of prisons. Fitzgerald and Sim (1982) describe this as the 'crisis of visibility', a term which refers to the notorious secrecy that surrounds prisons and what takes place inside them. The 'crisis of visibility' has an impact on the relations prisons have with the outside community and agencies, and how those agencies and the community relate to prisons.

Penal policy context: the post-Woolf era

U-turn in penal policy: 'prison makes bad people worse' to 'prison works'

During the period 1993-1997, the prison population increased steadily from 44,552 in 1993 to 61,114 in 1997 (see Table B.1, Appendix B). Despite signs of a decreasing prison population in the early period after the implementation of the 1991 Criminal Justice Act, a speedy retreat from the principles on which that Act was founded was undertaken by Kenneth Clarke and continued by Michael Howard. As Downes (1997: 9) argues, this sudden shift in the direction of policy was undertaken for party political reasons. Over the period 1989-1992, the crime rate had increased by over forty per cent, the recession had deepened, and the Conservative government's standing on law and order had declined compared to the Labour party. The government refused to acknowledge the link between crime and economic factors and thus resorted to 'one golf club strategy [or] more punitive policies' (Downes, 1997: 9).

This phase of penal policy development was imbued with managerialism and what Tony Bottoms (1995) has termed 'populist punitiveness'¹¹. A populist punitive approach appeals to politicians because they believe it will reduce the crime rate through general deterrence and incapacitation; it may help to strengthen the moral consensus against certain forms of activity such as drugs offences; and it will satisfy a particular part of the electorate (Bottoms, 1995: 39). The new politics of populism led to departures from conventional forms of policy-making. Under this framework, Paul Rock (1995) argues government ministers act with great speed and on impulse, consulting and liaising less with policy communities of experts, professionals, practitioners, civil servants, and researchers regarding policy decisions. During this period, shifts in penal policy were more influenced and determined by forces external to the prison system such as the Home Secretary, the general public, the media and Sir John Woodcock and General Sir John Larmont (Clark, 1997).

¹¹ Bottoms (1995: 40) employs the term 'populist punitiveness' to describe the 'notion of politicians tapping into, and using for their own purposes, what they believe to be the public's generally punitive stance'.

Thus, research conducted by Roger Tarling, the then Head of the Home Office Research and Planning Unit, which showed that crime levels would not be greatly reduced through incapacitative strategies was ignored (Tarling, 1993). In October 1993, Michael Howard advocated the idea that 'prison works' on deterrent and incapacitative grounds at the Conservative Party conference. He reasserted the Thatcherite 'law and order' rhetoric of the early 1980s by announcing a new 'law and order' package of 27 proposals which included the introduction of mandatory drug testing (MDT) in prisons, the building of six new private prisons, restrictions on bail and cautioning, and more punitive community service orders. Cavadino and Dignan (1997: 5) refer to this shift in policy as the 'law and order counter reformation'. In his speech, Howard argued:

Prison works. It ensures that we are protected from murderers, muggers and rapists - and it makes many who are tempted to commit crime think twice. This may mean that more people will go to prison. I do not flinch from that. We shall no longer judge the success of our system of justice by a fall in our prison population...I don't think prison should be a picnic...That is why I am determined to ensure that conditions are decent, but austere. I am particularly appalled by the drug taking in our prisons. This is not something we can tolerate. It is possible to test prisoners for drug use. We haven't been doing it up to now; we will be doing it in future (quoted in Lewis, 1997: 109).

'Just deserts' as the sentencing rationale was thus diluted by a renewed faith in the deterrent and incapacitative qualities of the prison. These ideas came to final fruition in the 1996 White Paper, *Protecting the Public*, which outlined the government's proposals for 'honesty in sentencing', automatic life sentences for serious violent and sex offenders, mandatory minimum prison sentences for drug dealers and burglars, and a new prison building and refurbishment programme (Home Office, 1996). Any debate regarding the aims of imprisonment, improvements to the regime, or implementing Woolf's proposals were clearly absent from the policy agenda. In fact, Howard announced a package of 'new austerity measures' in 1994 which included the earning of privileges through a new incentives and privileges scheme¹² and restrictions on home leave, temporary release and

¹² In July 1995, the Incentives and Earned Privileges Scheme (IEP) was introduced which involved the introduction of earnable and losable privileges to encourage responsible behaviour, hard work, and progress within the system. The aim was to create a safer, better controlled and more disciplined environment for staff and prisoners. For an evaluation of the Incentives and Earned Privileges Scheme,

access to telephones.

During this period, the prison system was undergoing further crises of 'containment' and 'control' which fuelled and legitimised the more punitive, austere, security and control focused agenda. There were disturbances at Wymott prison in 1993 and at Everthorpe prison in 1994. In September 1994, six high security prisoners attempted to escape and Semtex was discovered at Whitemoor prison. This was followed by another escape of three prisoners at Parkhurst prison in January 1995. These escapes led to the Woodcock and Learmont inquiries into prison security. The Learmont Report represented a departure from the general consensus emanating from the Woolf Report that the requirements of security, control and justice must be met and *balanced* if the prison system is to remain stable. As Morgan (1997b) argues, Learmont effectively dispensed with the notion of 'balance' by suggesting that the Statement of Purpose¹³ of the Prison Service be clarified so that the primary purpose of imprisonment is 'custody' and that everything else is subordinated to this basic requirement (see Learmont, 1995: para 3.39-3.40). Thus, Learmont did not conceptualise security and care as complementary, but as being in opposition to one another. The recommendations of the Learmont Inquiry therefore focused almost exclusively on security issues by advocating greater use of CCTVs, dedicated search teams, restrictions on visits and prisoners' property and improved physical security (see Learmont, 1995: para 7.1-7.120).

With Michael Howard's pronouncement that 'prison works', his emphasis on austere regimes, and his adherence to law and order rhetoric, prisoners deriving pleasure from drugs use could no longer be ignored or tolerated. During a period of overcrowding, crises in security, and reduced prisons budgets, it is interesting that the drug issue assumed such a high priority within the penal system. By 1994, the Prison Service and the politicians had 'come clean' and publicly admitted that there was a drug problem in British prisons. This area became a political challenge to Michael Howard. He

see Liebling et al (1999) and for a review of the literature on incentives in prison regimes, see Bosworth and Liebling (1995).

¹³ The Statement of Purpose is as follows: 'Her Majesty's Prison Service serves the public by keeping in custody those committed by the courts. Our duty is to look after them with humanity and help them lead law-abiding and useful lives in custody and after release.'

responded vigorously within his new plans for penal policy. As Carlen (1998: 99) argues the prison system had been opened up to the 'war on drugs'. Members of the policy networks, particularly those from penal reform groups and drug agencies, saw a clear relationship between Howard's discourses on the efficacy and austerity of prisons and the way in which prison drugs policy subsequently developed:

You can see certain things - MDT being the obvious one - as part of the crackdown which follows the brief period of liberalisation [after] the Woolf report...There was a period of what you could call the 'Prague Spring' for the prison system...It doesn't last very long. The tanks roll back in and this takes many different forms - the introduction of the incentive scheme is an example, MDT another....so it's part of the change of mood music of the period from about 1993 onwards.¹⁴

Agency status

A key trend in public sector reform during the late 1980s and early 1990s was the development of 'agencies'. Under agency status, quasi-autonomous bodies are established which are responsible for the development of operational policies within a policy and resource framework set by central government (Home Office, 1988b). The agencies are responsible for delivering the services within these resource limits. On 1 April 1993, the Prison Service was detached from the Home Office, hived off from direct government control and established as an executive agency. A Director General, Derek Lewis, was recruited from the private sector to facilitate these changes. His background was in television and he had no previous knowledge or experience of prisons. Under the new decentralised arrangements, more responsibility, control and authority for budgets, contracts, staffing and regimes was devolved from Prison Service headquarters to individual prison governors.

Three key documents underpinned the Prison Service's agency status: the Framework Document; the Corporate Plan; and the Business Plan. The Framework Document set

¹⁴Interview (024) with penal reformer, January 1998

out procedures for accountability and the 'stand off' relationship between the Home Secretary and the Director General. The Home Secretary would allocate resources and approve the Corporate and Business Plans and the Director General would be responsible for the day-to-day management issues. The document states, 'the Home Secretary will not normally become involved in the day-to-day management of the Prison Service but will expect to be consulted by the Director General on the handling of operational matters which could give rise to grave public or Parliamentary concern' (HM Prison Service, 1993: para 3.1). It was this rather vague and perhaps convenient division of labour between operational and policy matters which allowed Michael Howard to sack Derek Lewis in 1995 over the findings from the Learmont Inquiry. This illustrates the difficulties in separating policy from operational functions and policy formulation from policy implementation. These are interconnected processes which are impossible to disentangle.

In 1993, six principal goals were set for the Prison Service: to keep prisoners in custody; to maintain order, control, and discipline in a safe environment; to provide decent conditions for prisoners and meet their needs; to provide positive regimes which would help prisoners to address their offending behaviour and allow them as full and responsible a life as possible; to help prisoners prepare for their return to the community; and to deliver prison services using the resources provided by Parliament with maximum efficiency (HM Prison Service, 1993). Key performance indicators (KPIs) and targets were developed to measure progress towards these goals. The Corporate Plan outlined the strategies for achieving the goals over a three year period and the Business Plan set targets for the immediate financial year.

This new approach to public sector management had a profound effect on the way in which the prison system was managed and operated. It came to be dominated by 'institutionally-defined managerial goals' (Garland, 1990: 184), prioritising measures of performance and short-term goals rather than articulating a common purpose, moral mission or set of values. There was also a shift to focusing on the 'aggregate' level, rather than the individual offender or prison. For example, data on the key performance indicators are reported as national aggregates making it difficult to ascertain what is

occurring in individual prisons. The emphasis on the 'aggregate' also leads to a clash in terms of philosophy for professionals within the system who may come from social work or probation backgrounds which focus on the individual (Bottoms, 1995). Various scholars have argued that the system has become preoccupied with internal goals, rather than social goals, 'outputs' rather than 'outcomes', the aggregate level rather than the individual; and on internal system processes rather than external objectives (see Feeley and Simon, 1992; Bottoms, 1995; Garland, 1996).

The drug issue in prison was first given serious attention under these new arrangements and structures. For example, in 1996-97 year, a new KPI was introduced which was to ensure that the rate of positive random drug testing would be lower in the fourth quarter of 1996-97 than in the first quarter of that year (HM Prison Service, 1996a). In the next sections, I will first explore how the drug problem in prisons was reconceptualised during the period 1993-1997 and then examine the policy response.

A threat to order, control and discipline: reconceptualising the drugs 'problem' in prisons

During the mid-1990s, the drugs 'problem' in prisons began to be framed in new ways. The concern around HIV and public health issues during the previous phase began to diminish and there was an increasing focus on drugs as a problem of order, control and discipline. This shift in emphasis was linked to the punitive political context discussed above and to a growing awareness of drugs in prison as a problem of culture and currency with links extending into the wider community. During 1993-1997, official statistics¹⁵ indicated that the drugs 'problem' in prisons was increasing. The numbers of drug addicts notified to the Home Office by prison medical officers almost doubled from

¹⁵ Further official evidence on prisoner's drug use was generated by the OPCS in a survey on the physical health of prisoners in 1994, although prisoners were only questioned about their drug use prior to imprisonment. This showed that two-thirds (63%) reported having used drugs in the year before entering prison. The most commonly used drug prior to prison was cannabis. Levels of reported drug use were much higher among prisoners than the general population. For example, British Crime Survey figures show that 28% of males aged between 16 and 19 took drugs whereas 82% of prisoners under the age of 21 reported drug use (Bridgwood and Malbon, 1995).

1,941 in 1993 to 3,665 in 1996¹⁶ and their proportion out of all notifications increased by three per cent over this period (see Table A.1, Appendix A). This increase may reflect previous Prison Service initiatives, such as the introduction of the manual on care for drug misusers and policies and procedures for HIV/AIDS, as well as the 1995 prison drugs strategy which stressed identification, assessment, and testing (Home Office Statistical Bulletin, 1997: 14). The number of drug offenders sentenced to custody also increased dramatically from 4,835 in 1993 to 10,422 in 1997. In terms of the percentage of those sentenced to custody out of all drug offenders, there was a two per cent increase over this period (see Table A.2, Appendix A).

During this phase, informed members of the policy network suggested that there had been not just one drug problem, but something multi-faceted. They saw a variety of different problems experienced by different people with different drugs in different contexts. They disagreed however, as to whether drugs was primarily a problem for the 'individual' or for the 'institution'; whether it was a health problem or an enforcement problem; and whether it was an 'internal' problem within prisons or an 'external' problem extending beyond them. On the whole however, with some important exceptions, these influential groups tended to frame drugs as a problem for the institution, rather than for the individual; as an enforcement rather than a health problem; and as an internal rather than an external problem.

Drugs were particularly problematic when they became a dominant part of the prison culture. A 'culture' had built up around drugs within prisons during the mid-1990s. They had become an important currency which generated certain types of behaviours and problems for individuals and for the institution, including drug dealing, intimidation, threats, extortion, bullying, the accumulation of debts, and violence (ACMD, 1996). The fear of intimidation and violence was believed to have led to suicides, prisoners opting to be transferred to Rule 43 for protection, prostitution, bartering possessions, and failure to return from home leave due to failing to obtain drugs for others (see Leech, 1997;

¹⁶From the end of April 1997, the Misuse of Drugs (Supply to Addicts) Regulations 1997 revoked the notification requirement; therefore 1996 was the last year statistics were compiled (Home Office Statistical Bulletin, 1997).

Turnbull et al, 1994). A civil servant described drugs as a 'penetrating problem' within the institution:

*It is an evil that permeates every layer and area of a prison. It is a penetrating problem....There is nothing that it doesn't touch or impact upon.*¹⁷

Drugs had become one of the most potent, expensive and powerful currencies within the prison system. The type of currency within prisons determines how the system will operate. Currencies, such as tobacco, telephone cards and chocolate, have always existed. The problem was not so much that drugs had become a currency, but that in some prisons they had become very expensive leading to huge debts and violence. Sparks et al (1996) found that in prisons where cash economies operated, the price of drugs was high and a lot of money was generated through them. The illegality of drugs was also a key problem. For the first time, the currency being used not only breached prison disciplinary rules, but was also against the law. The Conservative administration was particularly concerned with the illegality issue and the public imagery of failing to take tough action on such activities¹⁸. The use of alcohol is also against prison rules and creates problems around violence and control. However, alcohol was not viewed as problematic and no overall strategy existed for alcohol misuse during this period. This suggests that the concern around drugs was set within a political rather than a practical agenda (Hewitt, 1996).

When drugs became a currency, it led to loss of control by the authorities over the prison environment. For example, the Larmont inquiry found that prior to the escapes at Parkhurst, drug misuse and drug dealing were pervasive within the prison and had led to an increase in assaults and violence between prisoners. An internal enquiry concluded that the prison 'had a serious drug problem [which was] greater than initially envisaged. The supply of drugs is spiralling out of the control' (quoted in Larmont, 1995: para 2.247). The notion that the problem was out of control was seen to be the key to the

¹⁷ Interview (020) with civil servant, January 1998

¹⁸ Interview (001) with civil servant, September 1997

drug problem among those most concerned with developing prison drugs policies. Drugs were no longer seen as 'functional' in keeping the system under control (as they had been in the 1980s), but as a disruptive, destabilising, threatening and dangerous factor:

The consequences of [drugs] affected the whole life of the prison in terms of potential violence, but also in terms of destabilising the whole system.¹⁹

It's by no means only about drug use in itself, although clearly that has problems not only for the atmosphere of the prison and also for prison discipline and order, but also public health risks...It is the overall sense that it leads to a more unpleasant and unmanageable environment.²⁰

Imprisoning more drug traffickers and offenders does not ensure that all drug-related crime will be controlled as the advocates of the 1991 Criminal Justice Act and subsequent legislation had hoped. Research indicates that many criminals continue to commit crime in the prison environment just as they had in the community (see Bottoms et al, 1990; Grapendaal, 1990; King, 1991) and drug traffickers continue to operate easily within the prison setting (see Early, 1991; Ruggiero, 1995). Drugs and drug dealing provides a source of status and 'employment' for some prisoners which continues on the outside on release (Ruggiero and South, 1995). As Ruggiero (1995: 66) observes, 'drugs cause some prisoners to become desperate and ill while others become rich and powerful'.

Although drug users in prison were seen to be difficult to engage in the regime and regular work programmes, it is important to emphasise that drugs are used as a means of coping with the pains of deprivation of prison life (Sykes, 1966; Irwin, 1980). For inmates who are locked up for 23 hours a day, drugs (particularly cannabis), provide a method of relieving the stress and boredom of being in prison, a way to pass their 'time' and an aid to sleep (Turnbull et al, 1994; Cope, 1999; Matthews, 1999). Some policy actors argued that the increase in drug misuse in prison could be viewed as a reaction to

¹⁹Interview (018) with penal reformer, December 1997

²⁰Interview (002) with civil servant, September 1997

the decline in the quality of prison regimes due to increasing overcrowding, cuts in prison programmes, and Howard's austerity measures introduced during the mid-1990s. Drug smuggling, trafficking, dealing and use within prisons had provided a way to pass time in prisons and could be compared to a 'game' which occupied a large proportion of prisoners:

...If the regime quality was fundamentally different, then we'd have a very different story in terms of drugs. I principally see it as a quality of regime issue which means the stultifyingly boring life is tempered by using drugs, mainly cannabis and in its wake, it becomes a control issue of bullying, violence, and trade...Therefore what you get is the collusion of principally families [and] friends breaking through that cordon sanitaire, plus the occasional prison officer deviates. And the whole thing becomes a great game.²¹

During this phase, there was also growing recognition amongst the policy network that the drug problem in prison extended beyond the prison walls in terms of links with crime and criminals on release, debts, trafficking, and problems for prisoners' families and friends. It was difficult for prisoners to break free of drug networks within prisons on release:

Another problem is your inheritance from whatever you do in prison, following you outside...Breaking free of these things - you just don't leave them behind. If you've been with a group of people, dependent on a group of people and been engaged in an activity...They're actually going to follow you through...They will come out, having mixed with a network of people, and because it's very often a local prison, they'll still go out into the same area in that same network of people.²²

The drug supply networks in prisons were inextricably linked to those operating in the community. Prisoners' families and friends were being pressurised to smuggle drugs into prisons, forced to assume responsibility for paying debts accumulated by their partners within prisons, and threatened and hassled by drug dealers operating within the community who had links with those inside prisons:

²¹Interview (005) with director of drug agency, October 1997

²²Interview (011a) with director of drug agency, November 1997

...Because of the amount of money involved in drugs, that began to seep out back into the community and we became aware of pressure that was being put on families outside of prison...payment being made outside of prison...The whole context spilled out beyond the prison.²³

Reflecting their orientation towards treating and caring for individual drug misusers, it was mainly those from drug agencies who expressed the problem of drugs in prison in 'individual' and health-related terms. For them, individual problems included people beginning their drug career in prison, links between drug misuse and offending behaviour, unsafe practices within prisons, problems around drug addiction and other health issues. Drugs misusing prisoners often lacked knowledge about drugs and experience of drug services and treatment in the community.²⁴ This group tends to be excluded from service provision and from society in general. The OPCS survey of prisoners showed that less than one third (31%) of drug users²⁵ had sought some sort of treatment prior to imprisonment either from a medical person (ie. doctor/nurse) or another professional (ie. counsellor, drug worker, outreach worker) (Bridgwood and Malbon, 1995). Similarly, in Maden et al's study of women prisoners, one third of the women defined as dependent reported no contact with treatment services before entering prison (Maden et al, 1990), but over half of the female and male prisoner samples indicated they would accept treatment if it was offered to them (Maden et al, 1990; 1991).

In conclusion, it is important to note that different drugs cause different problems for different individuals within different prisons (Turnbull et al, 1994; ACMD, 1996; Cope, 1999). In order to address the problems associated with drugs in prison effectively, this needed to be acknowledged by those involved in the formulation of policies and strategies. As a spokesperson from a professional association cogently argued:

²³ Interview (018) with penal reformer, December 1997

²⁴ Interview (026a) with director of drug agency, January 1998

²⁵ The proportion seeking treatment depended on the type of drug used with the majority who had used methadone (80%), heroin (70%), crack/rock (62%), tranquillisers (56%), and cocaine (54%) seeking help.

The cannabis problem is a problem of gangsterism and intimidation. Problems about use of heroin are essentially around health concerns. Those two might be linked because it might be the same supplier. It might be the same user, but putting watered down bleach on landings doesn't do anything to solve the problem around the violence and intimidation associated with cannabis and vice a versa. So you've got to sort out what is 'the problem'. Is it violence and intimidation we're talking about?...There's not one problem. There's a range of problems and you've got to be clear which one we're tackling. The odds are that as you deal with [one], you impinge on others.²⁶

The next section will explore the response to the drug problem in prison during this phase which took the form of the 1995 prison drugs strategy.

Response to the 'problem': the 1995 prison drugs strategy

In 1995, the Prison Service published a document entitled, *Drug Misuse in Prison: policy and strategy*. This represented the first comprehensive drugs 'strategy' within the prison system with clearly defined actions, priorities, objectives and targets. Reducing the level of drug misuse became one of the seven strategic priorities in the Prison Service's Corporate Plan and would be monitored by a new performance indicator based on the number of positive results from random drug tests²⁷. The reduction of drug misuse in prisons was to be achieved through local drug strategies²⁸ which focused on three areas: reducing the supply of drugs; reducing the demand for drugs and rehabilitating drug

²⁶Interview (021) with spokesperson for a professional association, January 1998

²⁷ The strategy focused exclusively on illegal drugs and did not incorporate alcohol or tobacco within its remit.

²⁸ The local strategies were expected to include the following elements: procedures to prevent drugs entering prison; drug testing arrangements; the formation of a multi-disciplinary team led by a Drugs Co-ordinator; an assessment of local needs and priorities taking into account equal opportunities implications; a timed implementation plan with performance measures, monitoring arrangements and regular strategy reviews; arrangements to identify individuals with drug problems; the provision of treatment, counselling and support; participation in multi-agency partnerships to co-ordinate treatment, help and support for inmates when they re-enter the community; and training for staff (HM Prison Service, 1995a: 3).

misusers; and measures to reduce the potential for damage to health of prisoners, staff and the wider community, arising from the misuse of drugs (HM Prison Service, 1995a: 2). Prison governors were responsible for developing and implementing local strategies which were to be agreed with area managers. The ACMD (1996: 32) welcomed this approach in the hope that it would help to close the wide gap that historically existed between national policy and local practice: 'national guidelines are essential to achieve a consistent, co-ordinated approach to drug misuse in prisons but their successful implementation depends on the local ownership of drug strategies by individual establishments.'

The 1995 prison drugs strategy was presented essentially as a two-pronged approach with measures to reduce the drugs supply and measures to reduce demand for drugs (see Prison Service, 1995a: 14-15). This was the first time that supply and demand reduction activities were combined within prison drugs policy. It was therefore an attempt to manage the issues which arise from the contradiction between asserting that the Prison Service will not condone drug misuse and achieving public health objectives to help drug misusers change their behaviour (Keene, 1997a). Within the policy discourse, there was a duality as it simultaneously contained both elements of help and punishment, providing it with much political appeal (Edelman, 1984). Concern was expressed by various sources that the new strategy might over-emphasise supply reduction and concentrate resources on security measures at the expense of demand and harm reduction (see ACMD, 1996; Penal Affairs Consortium, 1996; HM Chief Inspector of Prisons, 1996). These concerns were well-founded. In practice, the elements of security, punishment and control took precedence over help and treatment. The next sections will examine the main strands of the 1995 prison drugs strategy and the balance which emerged between them.

Mandatory drug testing

The most controversial element of the 1995 prison drugs strategy was the introduction of mandatory drug testing (MDT). In the United States, drug testing is used with arrestees, probationers, parolees, prisoners, and juvenile offenders as a method of detection to

provide the means for enforcing treatment requirements and for applying punitive sanctions. In 1989, the White House national drugs policy recommended that in order to deter offenders from using drugs, drug tests should be part of every stage of the criminal justice system from arrest to sentence (White House, 1989: 26). Despite the popularity of drug testing in the United States, there has been very little empirical research on its implementation and effectiveness for probationers, prisoners, and parolees (Wish and Gropper, 1990; Turner et al, 1994). During a visit to the United States in Spring 1993, the Director General of the Prison Service, Derek Lewis, was impressed with American drug testing programmes and believed they could be effective in reducing the drug problem in British prisons (Lewis, 1997). Up until 1995, drug testing in Britain had been used on a voluntary basis as part of community treatment programmes and in some prison-based programmes as part of the regime on 'drug free' wings.²⁹

The legal provisions for MDT are located in the 1994 Criminal Justice and Public Order Act which provides amendments to the Prison Act.³⁰ For the first time, it became a separate disciplinary offence for an inmate to use a controlled drug in prison without appropriate medical authorisation. It is important to note that MDT punishes the *taking* of drugs, whereas the general law (ie. Misuse of Drugs Act 1971) only prohibits possession. A person outside prison who has taken drugs and no longer possesses any cannot be prosecuted. Under the random testing procedures in 1995, ten per cent of the population of each prison was selected at random by computer. Selected prisoners were required, without warning, to provide a urine sample. The mandatory testing powers could also be used on reception; on suspicion; prior to risk-related activities such as temporary release and for persistent offenders. Drug testing on a voluntary basis continued to be used by prison health care staff for medical purposes and as part of drug treatment and compact programmes (HM Prison Service, 1995a).

MDT is undertaken by specially trained prison officers, rather than health care staff who are bound by professional and ethical codes which prevent them from participating in

²⁹ For example, voluntary drug testing was used in the Addictive Diseases Trust (ADT) drug treatment programme at HMP Downview.

³⁰ Amendments were also made to the Prison Rules and Young Offender Institution Rules.

activities without the consent of their patients. The MDT programme was resource and labour intensive³¹ and the cost for the programme was borne partly from the existing budgets of individual prisons and by diverting resources from other Prison Service areas. The initial cost of starting up the programme was £940,840 which only included the costs of building work and equipment, staff costs, staff training and Headquarters project staffing and expenses. In terms of running costs, in 1996, each MDT test costed £45.32, which included equipment, courier, lab analysis and staff costs, and 8.6% of these tests underwent a further confirmatory test at a cost of £28.82 (Hansard, Written Answers, 5 November 1996, col 430-431). For the year 1996-1997, £4.2 million was made available to prisoner governors to cover the costs of MDT, excluding laboratory and courier costs (Penal Affairs Consortium, 1996).

Although prisoners could not be forced to provide a sample for testing, those who refused could be disciplined for refusing to obey a lawful order. Prisoners who tested positive were liable to the usual range of disciplinary action on adjudication including additional days, loss of privileges and earnings, and administrative measures such as closed visits and removal of home leave. However, it was estimated that ninety per cent of the adjudication outcomes involve awarding additional days (ACMD, 1996). The Home Office estimated that MDT would increase the prison population by 300 (Home Office Statistical Bulletin, 1996b) and the annual cost for holding an extra 300 prisoners in custody would be over £7 million (Penal Affairs Consortium, 1996). Sanctions for positive tests are levied at the discretion of the governor. The ACMD (1996) warned that the sanctions being applied did not appear to differentiate between the type of drug involved and that this could lead to a sense of injustice amongst prisoners.

The Prison Service outlined several purposes of MDT including deterrence, identification for treatment programmes, helping prisoners to overcome peer pressure, provision of data on the scale and pattern of drugs use in prison, and information for a performance

³¹ These include the costs of laboratory contracts or on-site equipment for drug tests; prison staff time in escorting prisoners to sample collection area, in supervising sample collection and associated administrative work, in running and maintaining on-site drug testing equipment in some cases including participation in a quality assurance programme, and training time for staff involved in sample taking and operation of drug testing equipment (HM Prison Service, 1995a:9).

indicator of drug misuse (HM Prison Service, 1995b). Many key policy players argued however, that the link between MDT and treatment was not as sophisticated as it was presented in the strategy. MDT was primarily seen, particularly by those from penal reform groups and drug agencies, as a means of control and a method for inflicting more punishment, particularly for cannabis use:

*MDT is essentially a solution to a perceived cannabis problem. It's all about order and control. They try and put a gloss on it saying it helps to bring people forward for treatment programmes...That's not what it's all about.*³²

In February 1995, MDT was piloted initially in eight prisons. By Spring 1996, it was in place across the entire prison system. The great speed with which the MDT system was implemented reflected the priority that drugs had assumed on both the political and policy agendas. It was implemented in many prisons before the broader drug strategy was established. In particular, treatment provision was not in place prior to MDT. Because it was a mandatory requirement across the prison system operating within a legal framework, MDT was focused upon at the expense of other parts of the strategy. Another crucial factor was that the MDT results were the only drug-related key performance indicator (KPI) which was reported at a corporate level. As a result, MDT was often used as an indicator of the effectiveness of the overall drugs strategy. All of this was compounded by the political pressure to appear 'tough' on the drug issue in prisons. This legacy of emphasis and primacy on MDT persisted within the 1995 prison drugs strategy. This was recognised by the civil servants:

*Undoubtedly, MDT has taken too much focus for us... There was significant political pressure to introduce MDT and get it in quickly, which meant that we had a rather cockeyed approach in the sense that some prisons had MDT before they had a broader strategy in place. That legacy is still with us about needing to look at the balance.*³³

There's no doubt in the first roll out, because MDT was obligatory by a

³² Interview (021) with spokesperson for professional association, January 1998

³³ Interview (014a) with civil servant, November 1997

*certain date in every prison, the emphasis has been on the control aspects.*³⁴

Supply reduction

Supply reduction measures also featured prominently within the 1995 prisons drugs strategy. These included improved perimeter security (ie. patrolling, searching near perimeter fence, use of dogs and CCTVs); searching (ie. unpredictable, random searches by specially trained staff and dog teams); supervision of visits (ie. CCTVs, use of dogs, fixed furniture, searching visitors, and using closed visits³⁵ for prisoners found guilty of drugs offences); intelligence gathering and use of informants; and control of prescribed medication. These drug security measures were tied into the recommendations from the Woodcock and Learmont reports. As discussed above, the outcome of these two inquiries was a greater emphasis and more resources for security measures. For example, the total cost of the Learmont recommendations for Year One was estimated at £36 million (Learmont, 1995: Appendix Q). The Woodcock and Learmont enquiries had a knock-on effect with regard to the drugs strategy which ensured that the supply reduction measures had a very high profile, were taken seriously and implemented across the prison system. Carlen (1998: 7) aptly describes the new initiatives as representing a ‘fetishism of prison security’.

New powers were given to Dedicated Search Teams which were specially trained in searching both cells and prisoners for drugs. Media reports began to emerge that the new strip-searching powers given to these teams in Holloway Prison led to much intimidation and degradation amongst women prisoners. It was argued that this type of work attracted certain types of prison officers or the ‘heavy mob’ who wore a uniform of PVC leggings, Dr Martens boots and baseball caps (The Observer, 24 November 1996 quoted in Carlen, 1998: 7-8). Similarly, the security teams undertaking the searching and testing at Stoke Heath YOI wore special SAS style jumpsuits and heavy black boots (Howard

³⁴ Interview (019) with civil servant, December 1997.

³⁵ In closed visits, physical contact between the prisoner and the visitor is prevented by a physical barrier.

League for Penal Reform, 1996). Such symbolic distinctions between staff carrying out security and control functions and those undertaking health and treatment activities ensured that punishment and control aspects would remain visible and paramount. In 1996, there were 8036 drug finds in prisons and one third of these emerged from cell searches (HM Prison Service, 1997a).

Because visits were seen to be the major route by which drugs enter the prison, the greatest impact of increased security was felt amongst visitors to prisons. As part of the supply reduction measures, supervision of prison visits became much more intense. In March 1996, Michael Howard announced a pilot scheme in which those found using, trafficking or supplying drugs in prison would face closed visits. Although the ACMD (1996: 43) indicated support for many of the supply reduction measures, it voiced opposition to closed visits and argued that 'a humane visiting system is an integral part of the Prison Service's objectives of maintaining links with the community and looking after prisoners with humanity.' However, the increased searching, use of sniffer dogs, and CCTVs have made visiting prisons an intimidating and frightening experience for many visitors.³⁶ Police in the community began to work more closely with the prisons in terms of intelligence gathering, leading to raids on visitor centres connected to some prisons. These centres are supposed to be safe places where visitors can have refreshments, wait for their visiting time, use the washroom facilities, and obtain advice from centre staff. The raids were conducted insensitively. For example, some visitors were strip-searched in front of their children.³⁷ This has become a gendered issue as the majority of visitors to all prisons are women (including women's prisons) who often become coerced and pressurised into bringing drugs into the prisons (ACMD, 1996: 44). Various prisons posted up photocopies of news reports giving details of people being arrested for bringing drugs into prisons in the hope that it would deter other visitors. However, it is unlikely that these measures will act as a deterrent because the pressure to smuggle drugs in is too great. Many visitors fear that their partners and friends inside prisons will be attacked, bullied or even killed if they fail to bring drugs. As a civil servant admitted:

³⁶ Interviews (013) and (016) with directors of penal reform groups, November 1997

³⁷ Interview (013) with penal reformer, November 1997

*We've got some victims of drugs in prisons - usually women - who are under immense pressure to bring things in. As we've said to Ministers, it's very easy to say that these measures will deter...but, if my son was in prison and he said to me, 'Look, someone's going to knife me, if I don't get something in', you can imagine you might try to get something in.*³⁸

In 1995, 1,463 visitors were arrested for possession of drugs - an increase of over 50% compared to 1994. There was a slight reduction in 1996 with 1314 visitors arrested (HM Prison Service, 1997a). Visitor centres began to adopt a drug prevention role, for example, by putting up posters for visitors to advertise help and advice if they are pressurised into bringing in drugs. In May 1996, ADFAM National, the charity for the families and friends of drug users, developed a project³⁹ which is dedicated to working with prisoners' families and visitors to prisons around drug issues.

Treatment provision

Within the 1995 prison drugs strategy document, there was very little in terms of new proposals and resources for drug treatment initiatives. With regard to treatment, counselling, and support services, it was stated that 'it is not possible to advocate a particular programme or programmes which will meet the immediate needs of the prison, the longer term needs of the criminal justice system, and the needs of the individual inmates' (HM Prison Service, 1995a: 18). It was recognised that different programmes such as short educational programmes, self-help groups, individual advice and counselling, and therapeutic communities would be needed to match varying levels and types of drug misuse. However, it was not specified where these programmes were to be

³⁸ Interview (014b) with civil servant, November 1997

³⁹ The ADFAM National Prison Project – the Road to Release – aims to provide drug information and support to prisoners' families by running support sessions for families at Prison Visitors' Centres and Prisoners' Families Support Organizations; by offering training and advice to staff at Visitors' Centres and Prisoners' Families Support Organizations; by liaising with Prison Service Drugs Coordinators and prison-based drug services so that families are able to obtain accurate information about treatment services; and by developing links with community-based drug agencies in order to take and make appropriate referrals (ADFAM National, 1997)

provided, who would be delivering them, or how they would be resourced. Decisions regarding treatment provision were to be left to local prison governors. Prison managers were expected to make use of the resources and expertise of outside agencies, make contact with their Drug Action Team, and consult the SCODA directory of drug agencies (HM Prison Service, 1995a: 19). Outside agencies would be asked to provide advice as to what type of programmes might prove beneficial to prisons. Although the issue of funding for drug agencies was to be reviewed, their work was expected to continue and to be integrated into local drugs strategies with no new central funding. These agencies were generally funded by health authorities or charitable trusts and, in many cases, provided services at no cost to prisons.

Drug agencies working in the prison setting have always faced the dilemma as to where they position themselves within the system (ie. as independent professionals or as part of the penal establishment). The introduction of MDT altered the political environment of prison-based drug work and raised complex issues for agencies (Stokes, 1996). The premise that MDT would identify drug misusing prisoners for treatment placed tremendous pressure on drug agencies as there was insufficient treatment provision for MDT to work as a referral mechanism. Moreover, some drug agencies refused to work with MDT positives unless they were paid for working with this group. A clear separation between treatment and MDT would have ensured that the voluntary nature of treatment was maintained and that drug services were not swamped with cannabis referrals (Stokes, 1996). If agencies accepted referrals from MDT, this would change their position within the prison as they would become part of the MDT machinery, rather than independent.

There are similar debates about whether or not prison officers should be involved in drug treatment programmes. As we saw in the previous chapters, drugs tended to be an area solely for 'experts' within prisons, such as medical staff and external drug agencies. Under the 1995 strategy, there was an emphasis on a multi-professional and multi-disciplinary approach. All prison staff were to undergo basic training to increase their understanding of drugs, their effects, and the problems experienced by drug misusers to ensure that the strategy was successful and not undermined. Cultural clashes between

prison staff and service providers often occur. Prison staff tend to work within a very punitive institutional framework with their work centring around the needs of the institution, whereas service providers tend to adopt a more caring, client-centred approach with their work centring around the needs of individuals.⁴⁰ The security and control functions of prison officers raise difficult issues around confidentiality, particularly in relation to the other parts of the drugs strategy such as MDT and supply reduction. Because prison officers' primary responsibilities and skills are around security issues, these will always take priority and often conflict with treatment programmes. There is also a perception amongst *some* prison officers and governors that security and supply reduction activities constitute high status work compared with treatment, rehabilitative and welfare-oriented work. As a spokesperson from a professional association argued:

*Some prison service staff are more interested in sexy operations like dog searches and CCTV, than they are in things like...working with individuals to deal with their drug use problems...Most people would regard the second half of that as being sexier propositions than high walls, dogs and CCTVs, but the Prison Service don't, because that's where their minds are at.*⁴¹

The ACMD (1996: 96) argued that the limits of non-specialist prison staff in service provision needed to be recognised and recommended that they should be involved only in identification and assessment, the provision of basic information and advice, and health education programmes, while intensive therapeutic work with drug misusers should be restricted to dedicated specialists. Most drug agencies welcomed prison officers becoming involved in some forms of treatment provision, such as group work, as long as their activities were directed and informed by outside agencies.

⁴⁰Interview (030) with director of drug agency, February 1998

⁴¹Interview (021) with spokesperson from professional association, January 1998

Similar to the national drugs strategy, HIV and harm minimisation issues received little attention within the 1995 prison drugs strategy document. It may be that this was seen to be covered by the Prison Service AIDS Advisory Committee in their review of HIV/AIDS which was undertaken in 1992 and published in 1995 (HM Prison Service, 1995c). However, there is no mention of the work of the Committee or any link made between it and the prison drugs strategy. Local drugs strategies were expected to include education and information for all inmates on the risks and harms of drug misuse; options for coming off drugs; methods of reducing risk of cross infection; and the help available for HIV, other bloodborne infection diseases and drugs (HM Prison Service, 1995a). In their criticism of the strategy, the ACMD (1996: 38) suggested that in order for it to be more balanced and comprehensive, harm minimisation should be accorded a more important role and should involve three strands: reducing drug-related harm to individual prisoners, the prison regime, and the wider community.

Despite the lack of emphasis on harm minimisation within the strategy, important policy reforms were occurring quietly within the penal system. These included more liberal approaches to methadone maintenance, the provision of sterilising tablets to clean syringes and general provision of condoms. These reforms can be seen as the result of the pressure which had been building up over the previous phases of policy development from various committees and policy networks lobbying for greater congruence between community and penal provision.⁴² Guidelines on the use of methadone treatment were reviewed in 1995. As discussed in the previous chapters, Prison Service had always considered prescribing methadone on a long-term basis inappropriate and the only provision available was an accelerated regimen of seven days⁴³. Although abstinence

⁴² During 1993-1997, the debates around health care in prison continued. In his discussion paper on health care in prisons, the Chief Inspector of Prisons had expressed concern regarding the standards of care for drug misusers in prison and the key recommendation was that the responsibility for providing health care to prisoners should move from the Prison Service to the NHS (HM Inspectorate of Prisons in England and Wales, 1996).

⁴³ Prescribing methadone on a maintenance basis is available in other European prison systems including Austria, Denmark, Luxembourg, Spain and Germany (see Turnbull and Webster, 1998), New South Wales in Australia (see Hall et al, 1993), and as part of the KEEP programme in New York central jail at Rikers Island (see Peters, 1993).

was the overall aim of the 1995 UK prison drugs strategy, a working group of prison health care staff and outside experts concluded that methadone treatment within prisons should reflect more closely its use in community drug treatment programmes (HM Prison Service, 1995a). This would apply to those prisoners who were severely addicted to opiates and required longer term methadone treatment and ensure continuity of treatment for those prisoners who had been receiving methadone as part of their treatment in the community. The new guidelines for the clinical management of drug misusers are found in Health Care Standard 8⁴⁴ issued to all prisons in April 1995. The ACMD (1996) warned that a gap would remain between policy and practice unless steps were taken to ensure the implementation and rigorous monitoring of the standards. These were merely 'guidelines', meaning that prisons had not been mandated to implement them. Drug agencies were sceptical about the probability of their implementation:

*We get rainforests of paper sent out from Cleland House which are termed 'guidelines'. Why are they guidelines? Why not instructions? So for example, the Health Care Standards are guidelines...Health Care Standard 8 is a waste of paper.*⁴⁵

The AIDS Advisory Committee made a total of 39 recommendations in five main areas: research; staff and prisoner education; prevention, risk reduction and harm minimisation; counselling, psychological and social care; and medical aspects of HIV in prison (HM Prison Service, 1995c). Key recommendations included the provision of sterilising tablets; easy access to condoms and lubricants; and that education concerning HIV should directly address sexual behaviour and safer sex practices. In 1993, following the outbreak of HIV infection at Glenochil prison, the Scottish Prison Service made sterilising tablets available to clean syringes. The AIDS Advisory Committee also recommended that sterilising tablets be issued to all prisoners in England and Wales as part of a health and safety pack (HM Prison Service, 1995c). However, their introduction was fraught with difficulty. The first tablets were issued in October 1995,

⁴⁴ The objective of Health Care Standard 8 is to 'provide clinical services for the assessment, treatment and care of substance misusers comparable to those available in the community and appropriate to the prison setting' (quoted in ACMD, 1996: 134)

⁴⁵ Interview (026a) with director of drug agency, January 1998

but were subsequently withdrawn for health and safety reasons.⁴⁶ The Committee also recommended that condoms and dental dams⁴⁷ be made available in prisons by placing them in open containers in reception, the health care centre and other locations where prisoners could easily access them unobserved (HM Prison Service, 1995c). However, it remains to be seen if these initiatives have been implemented across the prison system.

Although it appeared from the drugs strategy document that interest in harm minimisation had diminished, policy reform was slowly occurring and the lessons from the HIV experience in prisons were being applied to other communicable diseases, such as Hepatitis C.⁴⁸ Therefore, harm minimisation and risk reduction measures were seen to be still on the agenda and pressures for reform of existing policy were still occurring, but were perhaps not articulated at the political level as prominently as some of the security and control measures in the 1995 prison drugs strategy.

It is clear from the 1995 prison drugs strategy document that the control and security elements were presented much more explicitly, with greater definition and detail compared to the treatment and harm minimisation elements which were much less explicit, detailed and concrete. Mandatory drug testing and the security initiatives were universal requirements across the prison system which were backed up by central funding and clear deadlines for implementation, while treatment and harm minimisation initiatives were to be established through guidelines, which would be subject to local decisions, resources and timetables. As prison drugs policy became more pronounced, defined and strategic, the contradiction between treatment and punishment grew much more acute. In an attempt to rebalance the strategy towards treatment and care, a policy network began to form and lobby for more emphasis and resources for treatment provision. The next section will examine their role in containing the increasing tensions between treatment

⁴⁶There were concerns that in the event of fire the tablets could give off a chlorine gas and also that they were dangerous if swallowed by prisoners. The Health and Safety Laboratory carried out tests on the tablets and found that the tablets presented a negligible risk to the prison environment. The tablets were reissued through a pilot scheme in the summer of 1998.

⁴⁷This is perhaps the first official acknowledgement that lesbian sex occurs within women's prisons and the first time that their needs were considered in HIV policy in prisons.

⁴⁸Interview (031) with civil servant, March 1998

and punishment.

The role of the policy network

In response to the new prison drugs strategy, interest in drug issues in prisons had increased and new players had been drawn into policy networks. For example, the ACMD (1996) published their report entitled, *Drug Misusers and the Prison System: an integrated approach*, which provided an important critique of the evolving strategy. Various groups produced discussion papers on different aspects of the strategy, such as the Penal Affairs Consortium (1996) and the Howard League for Penal Reform (1996). Drug issues in prisons were included in various official reports (see Department of Health, 1996; HM Chief Inspector of Prisons, 1996; 1997b; British Medical Association, 1997) and were the subject of various articles by practitioners and professionals attempting to influence the direction of policy (see Flynn, 1994; Tchaikovsky, 1994; Trace, 1995; Brazil, 1996; Stokes, 1996; Hewitt, 1996; Heyes and King, 1996; Rice, 1997). The new strategy also prompted research interest in this area (see Seddon, 1996; Gore et al, 1996; MacDonald, 1997; Keene, 1997a; Bird et al, 1997).

During this phase, the role of the policy network shifted from a position of setting the policy agenda, to one where they were responding to an agenda set from above. In many respects, they lost some of their power and influence, particularly during the early stages of the policy process. On the whole, there had not been open consultation with many of the key policy players over the details of the strategy, particularly those outside government. They had been sidelined. Prior to the implementation of the MDT policy, various members of the policy network attempted to lobby against its introduction. Their attempts proved futile, but they learned to adapt and deal with the new situation. In order to realign the strategy, they shifted their focus to extending treatment provision and the details of policy implementation and practice.

Before the implementation of the prison drugs strategy, there was much criticism and concern expressed by penal reform groups, drug agencies, civil liberties groups and other commentators regarding MDT and the associated security measures. In contrast, research conducted by Seddon (1996) showed broad support amongst Heads of Custody for these initiatives. This gap in opinion between those working within the prison system and those on the outside can be explained by the focus of Heads of Custody on day-to-day, short-term security and control issues, while those outside the system tend to be more focused upon welfare issues and long-term issues around control and safety (Dorn and Seddon, 1995). The main objections from those outside the prison system was that MDT would: constitute an invasion of the right to privacy; cause switching to Class A drugs which are less easily detectable compared to cannabis⁴⁹; lead to riots and disorder; discourage drug misusing prisoners from presenting for treatment; divert scarce resources away from drug treatment and prevention; lead to drug-free urine becoming a currency; result in drugs, urine and injecting equipment being carried internally, thus increasing the risks of HIV; increase tension between staff and prisoners with decreased use of cannabis; lead judges and magistrates to send offenders with drug problems to prison more often; have a detrimental effect on prisoners' relationships with family members and friends; not be backed up by effective treatment provision; and finally, drugs would be more scarce and therefore more expensive leading to more violence, debts, intimidation and bullying (see Flynn, 1994; Tchaikovsky, 1994; Trace, 1995; Riley, 1996; Berger, 1995; Hewitt, 1996; Heyes and King, 1996; Brazil, 1996; Gore et al, 1996; Howard League for Penal Reform, 1996; ACMD, 1996; Wayne, 1996; Penal Affairs Consortium, 1996; Rice, 1997).

Issues of race and gender were invisible within the strategy. Local drugs strategies were to include 'an assessment of local needs and priorities which takes into account the equal opportunities implications of tackling drugs in prisons' (HM Prison Service, 1995a: 3).

⁴⁹ For example, opiates are detectable in the urine for approximately two days after use while cannabis is detectable for approximately 5-10 days (moderate usage) and 20-30 days (chronic usage) (Penal Affairs Consortium, 1996: 12).

However, there was no specification as to what these implications might be and how prisons should deal with them. The ACMD (1996) stressed that the needs of women, minority ethnic prisoners, and young offenders needed to be more carefully considered in the development of the strategy. Concern was expressed that MDT would lead to new degradations and indignities in women's prisons (HM Chief Inspector of Prisons, 1997a; 1997b). Carlen (1998) illustrates how the construction of the MDT policy failed to consider and anticipate the differences in terms of implementation in women's prisons. There were also concerns that MDT would be applied in a discriminatory manner, in particular, there were arguments that the procedures should be ethnically monitored (Runciman, 1996; ACMD, 1996).

The overriding criticism of MDT was that it would cause prisoners to switch from using cannabis to Class A drugs, such as heroin, which are less easily detectable. Data from the pilot study indicated that the proportion of prisoners testing positive for opiates or benzodiazepines rose from 4.1% to 7.4%, while the proportion testing positive for cannabis decreased from 33.2% to 29.1% between the first and second phases of random testing, indicating the possibility of switching from cannabis to opiates and other drugs because of lower detection rates (Gore et al, 1996). This conversion to Class A drugs was also noted in the canton of Zurich, Switzerland when random mandatory drug testing was introduced. Their response was to cease testing for cannabis (Gore et al, 1996). In response to these initial findings, the Prison Service did not alter the implementation of MDT policy or procedures. Later, as part of its review of the prison drugs strategy, both quantitative and qualitative research on MDT was commissioned by the Prison Service to explore some of these issues. The fact that they were awaiting the results of this research was used by the Prison Service as a 'tactic' to deflect criticism away from the evolving strategy.

The various objections, warnings and preliminary research findings made little impact on the implementation of the policy. A spokesperson from a professional association who had been part of the lobby against the introduction of MDT recalled how he had been impressed with the planning by the Prison Service in this area:

*We could think up 15 good reasons why MDT could never possibly work. Then we had a briefing from the people from the Prison Service who thought up 25 reasons why MDT couldn't work and sorted out 24 of them. It was a very impressive piece of work - the way they had looked at every aspect of it...In planning terms, they did an excellent job.*⁵⁰

Given the statutory powers surrounding the MDT procedures, there was relatively little that could be achieved through lobbying to stop implementation. As Dowding (1995:144) argues 'the material power and legitimacy of the elected government can ride roughshod over any policy community'. The service providers recognised this and turned this into an 'opportunity' to argue that more treatment services were needed if drug misusers were to be identified through MDT. In their view, MDT had to be accepted, used as an indicator of drug misuse and a lobbying tool for expanding treatment provision:

*We couldn't just stand there and stamp our feet and say, 'this is a terrible thing', because you'd just be sidelined. What we did say is that the best thing it could do is give an indicative baseline of drug use in prison.*⁵¹

Furthermore, the Prison Service could no longer ignore or deny the problem of drug misuse in prisons because of the 'official' evidence base being produced through MDT procedures. For example, the key performance indicator for positive random drug testing indicated an increase from 24% in the first quarter of 1996-1997 to 24.2% in the fourth quarter (HM Prison Service, 1997b). For the drug agencies, the MDT results helped to raise awareness of the amount of drug misuse taking place in prison and therefore provided a starting point for discussion about what could be done in terms of drug treatment.

Civil servants within the Prison Service also voiced their concerns around the problems of implementing a solely punitive measure. In 1994, Phillipa Drew, then the Director of Custody and Tony Pearson, then the Director of Inmate Programmes, warned that MDT

⁵⁰Interview (021) with spokesperson for professional association, January 1998

⁵¹Interview (010) with director of drug agency, November 1997

could cause disorder and staff collusion with prisoners, if it was not introduced with incentives to remain drug-free and within a broader treatment strategy (The Guardian, 28 October 1994 quoted in King and McDermott, 1995: 195). The Chief Inspector of Prisons (1996) also argued that testing needed to be followed by either reward or treatment and that financial provision needed to be made for these elements. Similarly, the British Medical Association recommended that MDT should only be used with the provision of a full range of treatment services (BMA, 1997). A policy network comprised of drug service providers, penal reformers, civil servants and others began to lobby for centrally funded drug treatment initiatives to back up the MDT mechanism. Given their vested interests in this area, drug service providers played key roles in this policy network.

Pilot drug treatment programmes

In a limited sense, this policy network had been successful in their lobbying for treatment provision. By 1996, the Prison Service had introduced various types of pilot drug treatment programmes within particular prisons across the country.⁵² These programmes were centrally funded by the Prison Service Directorate of Health Care and independently evaluated by PDM Consulting Ltd. In 1995/96, £3.5 million was made available for the pilots and £5.1 million in 1996/97 (Penal Affairs Consortium, 1996). Initially, only twenty-two prisons were involved in the pilot programmes⁵³. Those prisons without pilot drug treatment programmes were encouraged to develop and fund their own arrangements involving external drug agencies. The pilots and evaluation were to be used as a basis to decide which facilities should be introduced across the entire

⁵² There were six main types of programmes piloted: detoxification units (specialised residential units offering detoxification regimes), three month treatment programmes (12 step abstinence based), therapeutic communities (units operating in isolation from the rest of the prison where prisoners live for nine to eighteen months. These are based on a generic programme devised by Phoenix House USA), education and counselling services, a co-ordinated area approach to throughcare, and community linked education, counselling and aftercare services (HM Prison Service, 1996b).

⁵³ By 1997, less than half (59) of all prisons had some type of centrally funded treatment initiative (House of Commons Hansard, 16 July 1997, Col 501).

prison system. The long-term aim was to provide a range of different drug treatment programmes within clusters of prisons, so that prisoners within each cluster would have access to treatment which corresponded to their assessed needs.⁵⁴ The treatment programmes could be seen as almost an afterthought in policy development to rectify an overly punitive policy and in response to liberal sectors within the Prison Service and the Home Office, as well as criticism from lobbyists. However, there was also a growing evidence base indicating that 'treatment works' and that the criminal justice system, particularly prisons, should be regarded as an opportunity for drugs intervention, which could not be ignored (Department of Health, 1996).

In general, the type of approach adopted by the Prison Service for the pilot drug treatment programmes was abstinence-based. Politically, this was a much more expedient and clear strategy to present in the context of a 'tough' policy on drugs, than one based upon harm minimisation. There were rumours that Michael Howard had been drawn in by Phoenix House USA and attracted to the idea of a hard-line, abstinence-based approach. There was also very little evaluative research on the various types of prison-based programmes in the UK and EU to make an informed choice (Turnbull and Webster, 1998). The twelve-step, abstinence-based programme at Downview prison run by Rehabilitation for Addicted Prisoners Trust (RAPt)⁵⁵ had also been heralded as a success throughout the prison system, won the Guardian Jerwood Award for charity work, and had also been independently evaluated (see Player and Martin, 1996; Bond, 1998). Services which had an abstinence-based, rather than a harm reduction perspective were seen to be favoured when it came to letting the contracts for the pilot drug treatment programmes and when prison governors, who were pursuing goals of drug-free prisons, decided on treatment provision for their establishments.⁵⁶

⁵⁴ Although the ACMD (1996) accepted that a full range of treatments could not be provided within all prisons, they recommended that in women's prisons and Young Offender Institutions which are geographically more isolated and not easily arranged in clusters, extra resources should be made available to enable a wider range of treatment options in each prison.

⁵⁵ This organisation was formerly known as the Addicted Diseases Trust (ADT). RAPt now runs programmes in Downview, Coldingley, Pentonville, Wandsworth and Norwich prisons.

⁵⁶ Interview (011b) with director of drug agency, November 1997

The Prison Service failed to undertake sufficient consultation when developing the treatment strand of the strategy. The service providers argued much could have been learnt by examining the development of services in the community:

Some of the commissioning decisions that they have taken look like they have not paid sufficient regard to the development of services in the community. This hell-for-leather search for abstinence - they thought that they could eradicate the drug problem within prisons by running a few programmes and detox units...the first tranche of service development was very much based around that.⁵⁷

Similarly, the Prison Service could have learnt from those who had experience of delivering programmes within UK prisons. Many of the pilot programmes were very expensive, high profile, and could reach only a minority of prisoners. What was missing were the low cost, low profile services which could reach a much broader group. As discussed in the previous chapter, such services had been developing in the UK from the late 1980s to early 1990s and had become a model for prison drug work:

I've always seen it as regrettable that in formulating that policy, they seemed to get very caught up in concerns about contract letting. They did their own thing rather than building upon what had evolved over a number of years in the UK. I very much saw a UK model of prisons drug work which had evolved in response to the need. All of the sudden that was run roughshod through by the Prison Service letting out some very large contracts which brought in new players who had not been previously interested in prisons work. So that we had very high profile TCS, 12 step programmes, but what we had very little of is the counselling, information and advice services. The services which are low cost, low profile, but which reach huge numbers of inmates...The Prison Service really did not speak to the established providers about what was going on...What they did do was to bring over people from the US - Phoenix US⁵⁸

The pressure of politics and time led to a policy response which was not 'rational' in any sense. To a certain extent, expertise within the UK was ignored. The policy and many of the programmes were not based on UK experience, but US experience and raised the

⁵⁷Interview (028) with director of drug agency, January 1998

⁵⁸Interview (026a) with director of drug agency, January 1998

issue of whether such 'policy transfers' would be effective:

Michael Howard was committed to all things American...The evolving drug strategy team...didn't know which way to go. The simple thing would have been to go and talk to the CDCU, the ACMD and look at the various documentation and things around and take a very slow approach to it and construct a strategy which was based upon the experiences of people working in the community. The pressure of time was one thing and influence was another...A lot of the things that we experience originate in someone having a quiet word in someone's ear somewhere.⁵⁹

It is not surprising that existing service providers in prisons resented the adoption of American-based programmes and practice. They had been liaising and sharing knowledge, experience and good practice between themselves and with their counterparts in other European countries. By 1994, seminars to improve the provision of drug services to prisoners had been organised by a group of British Prison Drug Services and the European Network of Drug and HIV/AIDS Services in Prison⁶⁰ had been established by the Cranstoun Projects Prisoner's Resource Service in the UK.

The development and sustainability of treatment provision

Despite the improvements in the level of treatment provision in some prisons through the pilot programmes, there was a clear consensus amongst the policy network that treatment generally remained ad hoc, patchy and unco-ordinated. The Directorate of Health Care conducted a survey of local drug strategies and found that 90% provided education and drug awareness activities; 80% had counselling and support from outside agencies (although the extent of this support varied); 66% were involved in throughcare and sentence planning; 30% had voluntary testing units; 30% had rehabilitation schemes, and the nature and extent of detoxification was variable (HM Prison Service, 1997a). In

⁵⁹ Interview (028) with director of drug agency, January 1998

⁶⁰ The Network organises seminars, produces a newsletter, and has two key aims: to bring together professionals working with imprisoned drug users to share information and expertise towards the development of good practice and to facilitate the cross-border referral of European prisoners who have drug problems and are outside their country of origin (European Network of Services for Drug Users in Prison, 1995).

particular, there was a lack of provision for short sentence prisoners (ie. less than 12 months), who are not subject to sentence planning and for remand prisoners.

Despite the historical emphasis on throughcare and release in the previous phases of policy and service development, sentence planning, throughcare and aftercare provision for drug misusing prisoners were crucial areas which had not been given sufficient attention within the 1995 strategy. This was mentioned by almost all those interviewed, viewed as a key problem on DATs (Duke and MacGregor, 1997), highlighted by the ACMD (1996), and one of the key concerns of the Department of Health Task Force on drugs (Department of Health, 1996). In order to ensure continuity of treatment, the ACMD (1996) recommended better links between prison and field probation officers and liaison between health and local authorities to ensure that the purchasing of services takes account of the needs of prisoners on release. They warned that 'until this is achieved, no strategy to tackle drug misuse in prison had any chance of success' (ACMD, 1996: 71). There had been a long history of conflict between prisons and health authorities in terms of which agency was responsible for drug treatment provision in prison and on release. Guidance issued by CDCU in October 1996 attempted to clarify the roles, responsibilities and resources in this area (CDCU, 1996). The Prison Service was to be responsible for purchasing and delivering drug services to prisoners in custody, while health authorities were responsible for those returning to the community on release from prison. The prison service, health authorities, local authorities, probation service, drug agencies and Drug Action Teams were all expected to play key roles in ensuring an effective framework for service provision and that services provided in prison linked to those in the community in order to achieve a smooth transition for drug misusing prisoners.

The treatment and throughcare strand remained underdeveloped because not all prisons received funding or central support for programmes, whereas every prison had the requirement and resources to implement MDT and supply reduction measures. In effect, security and control measures were top-down central initiatives, whereas treatment was essentially a bottom-up local initiative in the majority of prisons and depended on local enthusiasm. This was recognised by the civil servants within the policy network:

...The Prison Service has to put its money where its mouth is in terms of treatment provision. At the moment it has been a fairly unco-ordinated approach to particular pockets of money in particular parts of the country...There should be more on the resource planning front to make sure that there is a totality of provision across the system, rather than just on an ad hoc basis where some prisons are better off than others.⁶¹

We've got a disparity of distribution of the contracts because it's been done as a bottom-up approach, driven by local enthusiasm and some places have different priorities and have been slower off the mark. So we've got some very well-resourced areas and we've got some which are very poorly resourced.⁶²

Existing drug treatment provision was being undermined and compromised by the real pressures of population increases, budget cuts, lack of staff, difficulties in transferring prisoners to treatment programmes, competing priorities within the prisons and other institutional demands. During this phase, the sustainability of drug treatment was a key concern. Once the pilot drug treatment programmes had been evaluated, it was unclear as to whether they would be cascaded throughout the prison system and remain centrally funded and directed, or whether responsibility for funding and developing all drug treatment provision would be devolved to governors at the local level. As discussed in the previous chapter, central policy directives and guidelines can be ignored at local level. In considering all the pressures on their budgets, governors may choose not to spend the money on drug services or they may choose the cheapest, but not necessarily the most effective options. In order to ensure that prison-based drug services were prioritised, the ACMD (1996) argued that this funding should be ring-fenced. On the other hand, if the programmes were sustained, centrally funded, and expanded throughout the prison system, there was also the question of whether the voluntary sector could expand to meet the prison system's need. As a director of a drug agency commented:

[The question is] whether the organisations will be able to do it. And a subsidiary of that is what will they stop doing? The voluntary sector is notably fragile in terms of expansion...You could see a voluntary sector with

⁶¹Interview (002) with civil servant, September 1997

⁶²Interview (019) with civil servant, December 1997

*three-quarters of its work in the Prison Service and one-quarter in the community - a complete warping of that sort of relationship.*⁶³

During this phase, stories had begun to emerge of ‘crackpot’ services going into prisons to undertake drug work. This highlighted the need for vigilance in terms of which groups and services were allowed into prisons. Drug agencies working in prisons took the initiative and as the result of various seminars, meetings and conferences, produced a set of standards for drug services to be adopted by both purchasers and providers to ensure consistency across the prison system. The group produced a document which included standards for drug services, drug agencies and workers, drug treatment units, healthcare and prescribing, mandatory drug testing, implementation of drug treatment programmes, HIV and viral hepatitis prevention and treatment, working with families of imprisoned users, and home leave, visits and conditional release in throughcare (Cranstoun Drug Services, 1997). This was clearly a ‘bottom-up’ initiative emanating from the services themselves, rather than imposed by the Prison Service. Over the course of this phase, it is clear that service providers were working together to try to define the treatment strand of the prison drugs strategy and impose their experience and knowledge on its development.

The question of ‘balance’ in the 1995 prison drugs strategy

Despite the improvements in the level of treatment provision through the activities of the policy network, the strategy remained imbalanced and intensified the contradiction between treatment and punishment. Punishment, control and security initiatives had clearly overridden treatment, health and harm reduction initiatives. This was recognised by civil servants, penal reformers, drug agencies, and other policy influencers. The development of prison drugs policy was heavily influenced by the particular context, politics and environment in which the Prison Service was operating during this phase.

⁶³Interview (008) with director of drug agency, October 1997

The policy network was constrained by these parameters in what they could achieve in their attempts to manage and contain the growing tensions between treatment and punishment. The penal policy context was a much more powerful force than the drugs policy context of Tackling Drugs Together. The escapes from Whitemoor and Parkhurst prisons and the subsequent Woodcock and Learmont reports emphasising increased security, as well as Michael Howard's law and order agenda meant that supply reduction and MDT, received a much higher profile, greater priority and more resources. The Chief Inspector of Prisons, Judge Stephen Tumin, also added fuel to the political fire in February 1995 when he published his inspection report on Styal prison which included the headline-catching rhetoric, 'enter a shoplifter and leave an addict!' (HM Chief Inspector of Prisons, 1995).

The political goal was therefore to eradicate the problem and to publicly articulate this goal. This was recognised by the ACMD (1996: 1) which warned that the Prison Service needed to have realistic expectations about what could be achieved in terms of reducing drug misuse: 'unrealistic public and political expectations put undue pressure on the Prison Service and make it more difficult to strike the necessary balance between care and control'. Members of the policy network tended to view the 1995 prison drugs strategy and its emphasis on control as an exercise in public relations and a political response to the increasing pressure to be seen to be doing something about a problem which generates great political and public concern. The strategy was therefore an attempt to introduce some order over the drug problem in prisons which appeared to be 'out of control'. As a civil servant argued, it had great appeal because it sounded 'tough' and it could be measured, particularly the MDT element of it:

It sounds tough - maybe more because it's tangible and measurable...It's like you're taking control of the situation. The government, the authorities are taking control of the situation. All the messages from [the] drug culture in prisons are of a situation that the authorities don't have control. If you can actually test people and control them and put them into treatment, it's like you're taking control of the environment....It's this whole feeling of things spinning out of control, so the more you can take control over that it's considered good. It's the rhetorical attraction of it.⁶⁴

⁶⁴ Interview (007) with civil servant, October 1997

Policy development was also affected by the new 'managerial' discourses operating in drugs and penal policy. It was much easier to develop and implement a punitive mechanism in the prison environment backed up by law and performance indicators, than it was to develop treatment programmes across the system. As a penal reformer argued, 'you couldn't pass a law to say there will be all these counselling and agencies operating'.⁶⁵ Under the 'new penology' described by Feeley and Simon (1992: 462), drug testing is used as a mechanism for classifying prisoners, for measuring the distribution of risk within the prison population, for filling the gap left by traditional interventions, and for providing penal agents with 'a means to document compliance with their internal performance requirements'. Thus, mandatory drug testing was a technological solution to a human problem which could be measured and produce quick, tangible results. In contrast, treatment and rehabilitation involves individuals working together over time with results often taking a longer period of time to achieve. As Seddon (1996) argued, the managerialism within the strategy was too simplistic in the prison context and failed to provide a long-term solution.

The growing contradiction between treatment and control was also a manifestation of the divisions within Prison Service Headquarters and the separate responsibilities of the various directorates. This structural division is evident both in terms of the work that each directorate does as well as their geographical locations. During the 1995 strategy, drug treatment and communicable diseases were the province of the Directorate of Health Care located in Cleland House, and MDT and the security functions were the province of the Security group - Order and Control - located in Abell House. Due to these distinctions and separations, personalities and willingness to work together cross-directorally became of paramount importance. Underlying these structural divisions, there was also the notion that health and control issues should not be integrated or mixed. These divisions and differences within Prison Service Headquarters also filtered down into the prison system. Health care staff were not initially encouraged to get involved in the new drugs strategies as they were mainly seen to be about control and

⁶⁵ Interview (018) with penal reformer, December 1997

security. This had an impact on the balance between treatment and enforcement and it also led to much confusion within government, the prison system and the treatment agencies. As one civil servant argued:

There was a view held by previous senior people in the Service that health and control didn't mix and shouldn't mix and therefore health staff were discouraged from having anything to do with the establishment drugs strategy. They were told to keep very well clear of anything to do with MDT...You had therefore people who were quite expert who were discouraged from becoming [involved] because it had to deal with the disciplinary side as well. That was sort of a fundamental philosophy that treatment and mandatory testing and discipline didn't go together, so they stayed very separate.⁶⁶

It became clear during the 1995 strategy that there will always be some sort of 'balance' between treatment and punishment. The difficulty for policy-makers was to determine the 'correct' balance between the two activities and to accept that the balance might shift. Within the policy network, there were key differences in how the two activities were perceived (ie. as a continuum or two separate activities). Some described care and control as two separate continuums or dimensions which are not necessarily connected:

It's not a continuum with care at one end and control at the other....There are two continuums. You've got a continuum of care and you've got a continuum of control. You can have simultaneously no control and no care. Just because you've got no control, doesn't mean you've got a lot of care. Just because you've got a lot of care, doesn't mean you've got no control. They are two separate dimensions. In prison, you should have a lot of both.⁶⁷

Because the two initiatives came from different ends of the political spectrum - treatment and punishment. It would be very difficult linking them from the start....It wasn't really a proper strategy. MDT was introduced quite quickly.⁶⁸

⁶⁶Interview (019) with civil servant, December 1997

⁶⁷Interview (011b) with director of drug agency, November 1997

⁶⁸Interview (009) with civil servant, October 1997

In contrast, others argued that care and control should not be viewed as separate and independent, but integrated and working together:

*Part of the rigorous policy of trying to keep drugs out of prison is a caring policy in the sense that it protects weaker inmates. I don't think the two things should be seen as separate and independent...an integrated policy is what you would hope to see.*⁶⁹

*...At worst one should hope for an uneasy alliance where there will be tensions, but you can rub alongside each other. At best, I'm sure what we can achieve is an understanding that the two things work hand in glove. They are two sides of essentially the same coin and they are moving towards helping individuals make decisions about changing their lives...But they are also doing that on a macro level...They are doing it for the prison. They are doing it for the wider community...Although there will be times where they diverge, they fall out - a prisons blows up and there's a great big security issue and everything gets shut down, the balance can be restored. It just requires an understanding of what these things really are.*⁷⁰

At the end of this phase, some members of the policy network, particularly the civil servants, were optimistic that in theory a balance could be achieved between care and control, while others, mainly representatives of drug agencies and penal reform groups, felt that security concerns would always work to the detriment of any type of treatment and rehabilitation activities. Their scepticism may be a reflection of their experience on the ground of working with prisoners and within prisons. It was not only the drugs strategy which was subject to this tension between care and control, but it was an enduring conflict within all prison activities. The balance between treatment and punishment within the prison drugs policy was affected by the Prison Service Statement of Purpose which places security as the number one priority. Working within this context, drug treatment and counselling are destined to have a lower priority than enforcement and security. However, as a penal reformer argued:

Post-Woodcock and Learmont, there was almost an exclusive concentration

⁶⁹Interview (031) with civil servant, March 1998

⁷⁰Interview (028) with director of drug agency, January 1998

*on the first part of the Statement and security...The strategy on drugs reflects that dilemma virtually exactly. The concentration on the security side has taken priority and now there needs to be even more emphasis on the second part. Some people would say it is a continuum. You've got to crack down and deal with control and security first, then you deal with the counselling. The reality is, of course, that you've got to try to do them both together.*⁷¹

Another consideration is whether 'care' or treatment can be facilitated in a coercive environment such as the prison. This raises a number of complex issues and questions:

*Can you facilitate cure in a coerced environment? Is a prisoner ever free to make a decision?...Can we then say that he's a volunteer? I think that sort of balance faces the Prison Service in virtually everything that it does and drug treatment is no exception to this.*⁷²

There was also the view that effective 'treatment' could never take place in the prison:

*How can you treat people in captivity? We know it doesn't work with animals. Why don't we know it with people? You can't punish me to stop me smoking or drinking. We've come so far with alcohol and cigarettes. With drugs, we think we can beat it out of you, or punish it out of you.*⁷³

*What's problematic is attempting to implement interventions that are welfarist in approach in an environment which is about punishment and retribution....People are trying it. People are trying to develop whole rehabs in prison. Rehabs - I mean rehabs are places where there's the concept of therapy 24 hours a day. Therapy in a place where you're incarcerated - there's a definite conflict there.*⁷⁴

At the end of this phase, the continuing dilemmas for the policy network were to grapple with the contradiction between treatment and punishment, to attempt to shift the focus of policy away from security and punishment and to make the treatment strand of the

⁷¹Interview (018) with penal reformer, December 1997

⁷²Interview (018) with penal reformer, December 1997

⁷³Interview (029) with penal reformer, February 1998

⁷⁴Interview (006) with director of drug agency, October 1997

strategy more explicit and defined. Their ideas and activities informed the review of the 1995 strategy and the next phase of policy development which will be explored in the next chapter.

Conclusion

During the period 1993 to 1997, important shifts and changes occurred in the development of prison drugs policy. The first comprehensive drugs strategy was developed, the Prison Service had been formally incorporated into drugs policy at the national level, and prisons were expected to become involved in drug issues outside the prison walls through local partnerships. The drug issue in prison had finally been acknowledged at a political level and had become a highly politicised issue. It was increasingly framed as a problem of order, control and discipline which threatened the stability of the prison system. The response was to impose order on a problem which was perceived to be spiralling out of control. A more explicit prison drugs policy began to develop and interface with the overall frameworks of both penal and drugs policy. As policy became more explicit and defined, the contradiction between treatment and punishment became more intense.

The political context and the emphasis on managerialism during this period ensured that the new prison drugs strategy was dominated by punitive, but measurable, mechanisms such as MDT and increased security. Drug treatment initiatives emerged as an afterthought in policy development and in response to pressure from a policy network which began to lobby for greater emphasis on treatment. This policy network was led by drug service providers who saw the opportunity for expanding their work in prisons and securing funding for it. During this phase, it appears that policy-makers and politicians were less confident with existing approaches to dealing with the drug problem in British prisons, failed to consult many of those who had experience in this area, and looked instead to the United States for policies and programmes which could be transferred. Despite the attempts of the policy network to rebalance the 1995 prison drugs strategy, there was a clear consensus that enforcement, punishment and control aspects remained

the key focus and priority. In May 1997, the Labour government was elected to power presenting new opportunities for the policy network to express their concerns and views, influence the development of policy, and reformulate the existing strategy. This period will be explored in the next chapter.

Chapter Six

1997- Eradication to Realism?

Introduction

The focus of this chapter is on the period from mid-1997 and outlines the main developments in prison drugs policy which are planned for the next decade. On 1 May 1997, Labour won the general election. Their victory heralded the opportunity for new ideas, discourses and issues to infiltrate policy agendas. However, during the lead up to the election, the party had successfully reinvented and repositioned itself as New Labour signalling 'the end of Old Labour, old policies and old welfarism' (MacGregor, 1998d: 251). 'Soft' policies on crime, drugs, welfare dependency, and the family were replaced by 'tough' new policies. As it will be argued in this chapter, although there have been significant changes and reforms within public policy since the election of New Labour, the remnants of Tory populism remain and some of the new policies possess a striking continuity to the old. During this period, 'policy feedbacks' or the ways in which the legacy of established policies and inherited policy structures shape and constrain what is possible within policy development have been significant for the new government (Skocpol, 1992). Policy development in all areas, including prisons and drugs, has also been heavily influenced by transferring the ideas and discourses from the Clinton administration in the United States.

This chapter begins by highlighting the main developments in drugs and penal policy since the 1997 election which provide the backdrop for the changes within prison drugs policy. Borrowing ideas from American drugs policy, an anti-drugs co-ordinator or 'drugs czar' was appointed who was to guide, co-ordinate and implement the new

national drugs strategy. The new strategy did not however mark a significant departure from the previous one, *Tackling Drugs Together*. The 'managerial' discourses around assessment, targets, performance, partnership and co-ordination intensified. Despite the increased focus on prevention and treatment, it will be argued that the punitive discourses of 'enforcement', 'control' and 'punishment' have endured. Policy-makers and politicians have become increasingly preoccupied with the relationship between drugs and crime and the role of the criminal justice system in dealing with drugs was further enhanced. In August 1997, there were calls from various Labour MPs and senior police officers for a Royal Commission on drugs and a national debate on decriminalisation (The Guardian, 11 August 1997; 18 August 1997). However, New Labour remains firmly opposed to any debate around legalisation or decriminalisation. In relation to penal policy, it will also be argued that developments under Labour have not indicated a fundamental overhaul of previous Conservative policies. Labour's 'tough on crime' policies have not been successfully integrated with their 'tough on the causes of crime' policies and the populist punitive rhetoric of earlier phases of policy development has continued.

In the latter part of the chapter, I explore the nature and extent of the drug problem in prison by examining the results of three key pieces of research commissioned by the Prison Service and their review of the 1995 prison drugs strategy. As Spector and Kitsuse (1977) argue, an official response or implementation of policy is not the final stage of a social problem. The process continues whereby 'second generation' problems arise through existing policies and form the basis for new responses or policy reforms. In the construction of second generation social problems, 'assertions about the inadequacy, inefficacy, or injustice of the procedures may themselves become the conditions around which new social problem activities are organized' (Spector and Kitsuse, 1977: 151). Thus, during this phase of policy development, the concern was not so much around the drug problem itself, but with the policies and procedures which had been designed to eradicate it and the growing contradiction between treatment and punishment.

The evaluation of the 1995 prison drugs strategy highlighted problems around mandatory drug testing (MDT) procedures and inadequacies in treatment provision. The revised

1998 strategy represents an attempt to ameliorate some of the problems raised by the policy network during the previous phases of policy development. In many ways, these reforms denote a new 'realism' or pragmatism in relation to tackling the drug problem in prison compared to the previous strategy and an attempt to rebalance the strategy towards treatment and care for drug misusing prisoners. However, it will be argued that the basic punitive framework for delivering the strategy remains intact and the emphasis on the discourses of 'security', 'control' and 'punishment' has continued. It remains to be seen whether the balance between treatment and punishment will be dramatically altered. In the process of attempting to rebalance the new strategy towards treatment, the policy network around prison drug issues has been reshaped with drug agencies entering into more formalised partnerships with the Prison Service. Furthermore, the final section of the chapter explores the impact of prison drugs policy on wider policy development and suggests that some of the initiatives which began in the prison, such as testing and coerced treatment, have now gained greater acceptance and have been extended outside to the community.

Drugs policy context: 'breaking the vicious circle'

The attention given to the relationship between drugs and crime and the role of the criminal justice system in dealing with the drug problem during 1993-1997 was continued and reinforced by the new Labour government. In opposition, Labour portrayed the drugs and crime problems as inextricably linked and produced a document entitled, *Breaking the Vicious Circle*, which outlined their proposals to tackle drug-related crime (Labour Party, 1996). Drawing upon selected pieces of research, Labour policy on drugs was to be underpinned by the following key principles: drug treatment works; drug treatment is cost-effective; coerced treatment is just as effective as voluntary treatment; drug testing helps to identify those with drug problems and to ensure they conform to treatment regimes; and offenders should be kept in treatment for a minimum of three months.¹ Within Labour's election manifesto, three main commitments in

¹See Hough (1996) for the review of literature on which many of these principles are based.

relation to drugs were outlined which they pursued once in office: the appointment of an American style 'drugs czar' who would be responsible for implementing the new national drugs strategy; the introduction of a new treatment and testing order based on the US drug court models in Dade County, Miami; and the extension of access to voluntary testing for all prisoners.

Appointment of UK Anti-Drugs Co-ordinator

The concept of a 'drugs czar' was put forward initially by the Bush administration in 1989 in response to the growing public concern regarding drugs in the United States. However, successive drug czars, including William Bennett and Barry McCaffrey, have been criticised for failing to meet expectations (Jenkins, 1997). The idea of a high-profile individual leading and co-ordinating action against drugs provides visibility to an issue of great public concern and may allow the government to deflect attention away from itself and potential policy failure. In the UK, there were over 200 applications for the position of 'drugs czar' or anti-drugs co-ordinator, including doctors, drugs specialists and academics (The Guardian, 6 October 1997). Many of those working within the drugs field expressed concerns regarding the disproportionate emphasis on enforcement and the shift towards combative language in the government rhetoric around the appointment and the American label of 'drugs czar' (see also Jenkins, 1997; Eaton, 1997; Strang et al, 1997). However, civil servants argued that the appointment was not intended to signal a fundamental shift in drugs policy and the person's role was to co-ordinate action on drugs and build upon the existing strategy, *Tackling Drugs Together*. It was important that the person appointed could demonstrate that s/he had the confidence of all the principal professions and interest groups. However, it would be difficult to fulfill the expectations of all the actors involved in drugs policy networks. There was speculation amongst key policy players and within the press that the government was interested in appointing a police officer to underline the continuing emphasis on enforcement (The Guardian, 6 October, 1997; Eaton, 1997).

In the end, however, two appointments were made. On 14 October 1997, Keith

Hellawell, the Chief Constable of West Yorkshire police, was appointed to the position of UK Anti-Drugs Co-ordinator and Mike Trace, the director of the prison-based treatment agency, RAPt (Rehabilitation for Addicted Prisoners Trust) was appointed as Deputy Co-ordinator. The appointments were billed as a 'dream ticket' in the media in that both enforcement and treatment aspects were covered (The Guardian, 15 October 1997). This appeared to signal a commitment to ensuring that action and policy on drugs would be balanced between the treatment and punishment dimensions. There was also the potential to highlight prison issues more prominently in future drugs policy debates as the Deputy had an established reputation in prison-based work. The Co-ordinators report directly to the Cabinet Sub-Committee on Drugs Misuse. Their role is to provide the day-to-day leadership and focus for implementing and developing the government's drugs strategy, scrutinise the performance of government departments and other agencies against the actions, objectives and performance indicators set out in the strategy and produce an annual report and anti-drugs plan for implementation in each succeeding year (HM Government, 1998a: 29). After their appointments were announced, the Co-ordinators embarked on an intense period of familiarising themselves with the existing approach to drugs, reviewing research and consulting with key groups and individuals in the drugs field. After six months, they developed a new national drugs strategy.

The 1998 national drugs strategy: Tackling Drugs to Build a Better Britain

In April 1998, the government introduced a new strategy for tackling drug misuse entitled, *Tackling Drugs to Build a Better Britain*. It represents continuity with the previous phase of policy development, but also signals important changes. Although the new strategy was to build upon *Tackling Drugs Together*, four main weaknesses were identified with the previous one: it focused on structures rather than results; it treated drug misuse largely in isolation from other social and environmental factors; it advocated partnership without making sufficient structural and fiscal changes to support it; and it was too short-term and did not bring together common research, information and

performance bases (HM Government, 1998a: 9). The 1998 strategy was to run over a longer term of ten years as opposed to the previous one which ran for only three years. For the first time, drug problems were seen to be linked to other social and environmental problems such as unemployment, homelessness, and social exclusion. Drugs policies were therefore expected to interface with other social policies including welfare-to-work, social exclusion, youth justice, education, public health, and community safety and with other policy structures such as the Social Exclusion Unit². The new anti-drugs effort was to be targeted on the geographical areas of greatest need and risk and upon drugs which cause the most damage, such as heroin and cocaine. Under the 1998 strategy, the 'managerial' approach to the drug problem intensified with the various anti-drugs activities being subjected to a programme of rigorous and objective measurement, monitoring, evaluation and research. This was to be achieved through the Co-ordinator's Annual Report and Plan of Action Against Drug Misuse, annual reports from Drug Action Teams, regular reviews published by the statutory Inspectorates, quality indicators for the core statutory agencies, research and information, independent strategic evaluation and consultations or the process of 'listening and learning' (HM Government, 1998a: 35-36). In order to reduce competition between agencies, performance indicators at the corporate level were to be developed. Under the new strategy, there was an explicit commitment to base future policy and practice on real 'evidence', rather than rhetoric. This shift was welcomed by professionals and practitioners working in the drugs field (see Farrell and Strang, 1998).

For the first time, there was also a commitment to re-distribute drugs spending and shift resources towards treatment, rehabilitation, prevention and education. The total government expenditure on drugs-related activities for 1997/98 was estimated at £1.4 billion. This figure, as compared to £500 million quoted in 1993/94, was viewed as representing a more realistic assessment of the drugs-related proportion of generic activity (HM Government, 1998a: 30). It was estimated that 62% was spent on

²Under the government's definition, social exclusion is the outcome of people or areas suffering 'from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health, poverty and family breakdown' (Social Exclusion Unit, 1997: 1). The Social Exclusion Unit was established in 1997. It deals with issues which cut across the boundaries of government departments and it aims to improve government action in reducing social exclusion by producing 'joined up solutions to joined up problems'. It is staffed by a mixture of civil servants and external secondees and reports to the Prime Minister (Social Exclusion Unit, 1997)

enforcement-related work which was mainly reactive and not drugs-specific (police, court, probation, and prisons); 13% treatment; 12% education and prevention; and 13% international supply reduction. These estimates suggest that no more than one-third of the total is spent on prevention as opposed to dealing with the consequences of drugs (HM Government, 1998a). The strategy proposed a shift away from reactive expenditure and dealing with the consequences of drug misuse towards investment in prevention. New funds were to be generated from seizing the assets from drugs traffickers and channelling these into anti-drug programmes. The Government's Comprehensive Spending Review (CSR) also allocated an additional £217 million to departments to fund additional pro-active anti-drugs work over the years commencing 1999/2000 (DPAS, 1999). These new resources are conditional on departments achieving better co-ordination and focus in their work around drugs and developing effective performance measurement and evaluation systems so that efforts are based on 'what works' (HM Government, 1998b).

The strategy is organised around four elements: young people, communities, treatment, and availability. The main aims are to help young people resist drug misuse in order to achieve their full potential in society; to protect communities from drugs-related anti-social and criminal behaviour; to enable people with drug problems to overcome them and live healthy and crime free lives; and to stifle the availability of illegal drugs on the streets (HM Government, 1998a). Similar to the 1995 drugs strategy, emphasis on enforcement, punishment and the drugs-crime link continued. For example, research was quoted which provided evidence of the 'growing clarity of the relationship between drugs and crime'³ (HM Government, 1998a: 18). Under the aim 'to protect our communities from drug-related anti-social and criminal behaviour', a key objective was to 'reduce the levels of repeat offending amongst drug misusing offenders'. In order to achieve this reduction, one of the main activities was to implement drug treatment and testing orders and promote caution plus schemes in the community. Prison-related aims and objectives also figured prominently in the new strategy. A key treatment objective was to increase the participation of problem drug misusers, including prisoners, in drug

³See Gossop et al (1995) quoted in Department of Health (1996) and Bennett (1998).

treatment programmes. In particular, throughcare and aftercare arrangements for drugs misusing prisoners were to be coherent, focused and linked to provision in the community. The reduction of the supply of drugs within prisons continued to be emphasised as a key availability objective (HM Government, 1998a).

Partnership and co-ordination at all levels was a continuing theme. A new body, the UK Anti-Drugs Strategic Steering Group, was established to assist the Co-ordinator in assessing the overall progress of the strategy and planning for the future. The steering group was to include senior civil servants and representatives of independent bodies, drug agencies, local government, business, and Drug Action Teams. In addition, four new Strategy Support Groups were to be established – one group for each aim of the strategy – which would report back to the Steering Group. Their role was to monitor progress against each aim, assess the need for further support in its implementation, consider emerging training, research and information needs and monitor resource implications (HM Government, 1998a: 29). These new structures represent a more formalised forum for policy networks around drug issues, particularly for those agencies and organisations represented on the groups. They also signal a change as many agencies involved in policy networks move from pressure group and advocacy functions on the outside of the government machine towards becoming incorporated as ‘partners’ in government policy and implementation.

The main structures developed under the previous strategy, *Tackling Drugs Together*, were to remain intact. The Central Drugs Co-ordination Unit was renamed the UK Anti-Drugs Co-ordination Unit and continued to support the monitoring and implementation of the strategy. Drug Action Teams (DATs) and their associated Drug Reference Groups (DRGs) continued to be the main mechanism to ensure that the strategy was translated into action at the local level. An interim evaluation of DATs in 1997 concluded that they had been successfully established across the country; improved relations and communication between the various agencies; and many initiatives had been implemented or co-ordinated by the new structures (Duke and MacGregor, 1997). However, community safety and criminal justice were viewed as one of the most difficult areas to impact upon. In particular, prisons were seen as difficult to engage in DAT and DRG

structures.

Prison Service representation is usually dependent on whether DATs have a prison within their catchment areas. At the time of the research, just over two-thirds (69%) of DATs and one third (29%) of core DRGs had Prison Service representation. In some cases, prison representatives were poor attenders or prisons would send different representatives to each meeting or junior representatives. Prisons were not considered to be key players in the DAT structures. No DAT was chaired by a prison representative and only 7% of DAT Chairs and 15% of DAT members considered prisons as key players. Prisons were mentioned frequently by both DAT Chairs and members as agencies which needed to be involved more in the partnership structures (Duke and MacGregor, 1997). As highlighted in the previous chapter, structural problems around coterminosity of boundaries were viewed as real impediments to partnership work with prisons. A key difficulty with prisons is that they are neither national nor local structures and therefore do not have the same commitment as other DAT agencies to the local area. Prisons were also considered to be different 'culturally' from the other agencies represented on DATs as they have no history of joint working, work within a punitive rather than rehabilitative culture and are often located geographically away from the community and other agencies. It was also found that other agencies represented on DATs also lacked understanding of prisons and the constraints within which they work. Some DATs had attempted to overcome these difficulties by holding DAT meetings at their local prison (Duke and MacGregor, 1997). Under the 1998 strategy, the Prison Service was encouraged to direct resources from within their budgets to drugs-specific partnership and give this work priority in their business plan (HM Government, 1998a).

Penal policy context: 'tough on crime, tough on the causes of crime'?

During the early 1990s, the Labour party had begun to challenge the Conservative government on criminal justice issues. New Labour altered its traditional image of being 'soft on crime' to presenting itself as the 'party of law and order' by promising it would

be 'tough on crime, and tough on the causes of crime' if elected (Blair, 1993). The opinion polls indicated that the public had gradually become more confident in Labour's new populist rhetoric and image (Downes and Morgan, 1997). However, little serious debate occurred around law and order issues during the 1997 campaign because the three main political parties were espousing similar proposals, policies, and discourses. Moreover, as Heidensohn (1998: 170) argues, much of the election was fought over the nature and character of politics and the integrity of politicians, rather than substantive policy issues, such as crime, drugs and law and order.

In its first two years in office, the Labour government introduced and implemented many of its own law and order ideas, but it also continued to develop some of the policies which were proposed by the Conservative government. It is clear that the populist punitiveness of the Tories has endured. For example, the 1996 White Paper, *Protecting the Public*, led to the *Crime (Sentences) Act 1997*, and received Royal Assent before the election. However, it was left to the new government to decide whether the provisions of the 1997 Act should be commenced. The new Home Secretary, Jack Straw, announced quickly after the election that significant provisions⁴ within the Act would be introduced. Similarly, although New Labour claimed it was committed to reducing the prison population, there is no evidence thus far that the 'prison works' discourse has been successfully overturned (Morgan, 1999). The prison ship docked in Portland, Dorset, which had been commissioned from the New York prison authorities by the Conservative administration in 1997, was put into operation by Jack Straw shortly after he took office to provide more prison accommodation. By 1998, the average prison population had reached an all-time high of 65,299 (see Appendix B. Table B.1).

Prison numbers are to be managed executively through the use of home detention orders which involve electronic tagging and allow for the early release of short-term and medium-term prisoners (ie. serving sentences of three months to four years). However, there is no indication of a return to the decarceration policies which were at their height

⁴These provisions include mandatory minimum sentences of seven years for conviction of Class A drug trafficking offences for the third time, automatic life sentences for second conviction for a serious sexual or violent offence, electronic tagging for 10-15 year old offenders, and abolition of consent requirements for certain community penalties.

during the early 1990s before Michael Howard pronounced that 'prison works'. Moreover, the Home Affairs Committee Report (1998) on alternatives to custody proposed that community sentences were not more effective at reducing recidivism than imprisonment and that they needed to be made more effective and tough. The Labour government has failed to engage with the more fundamental question of 'what are prisons for'. Any debate or proposals which would involve a radical overhaul or transformation of the prison system, particularly in terms of its overall aims or purposes, appear to be absent from the policy agenda.

The government's new ideas for criminal justice are located in the Crime and Disorder Act 1998 which focuses on three key themes: youth justice reform, community safety and local partnerships, and improving the performance of the criminal justice system by reducing delay. As in other areas of the public sector (see Cutler and Waine, 1997; Butcher, 1998), the managerialist discourse with its emphasis on targets, measurement, performance and partnership has also intensified under the new government. One key example is the establishment of new local partnerships to reduce crime and disorder consisting of representatives from local authorities, police and other statutory agencies. Their role is to conduct audits of the levels and patterns of crime in their local areas, consult their local communities, develop strategies and targets for tackling crime and disorder, and measure and report their performance against these indicators (see Home Office, 1998a: 5). The Crime and Disorder Act contains 121 sections introducing wide-ranging provisions such as anti-social behaviour orders, parenting orders, detention and training orders, extended supervision for sexual and violent offenders, local child curfews, the abolition of the *doli incapax* rule⁵, child safety orders, a new Sentencing Advisory Panel and an extensive range of measures to reform the youth justice system (see Home Office, 1998a). The treatment of youth within the Act allows for intervention at an earlier stage of an offender's history and signals a fundamental shift in Labour's thinking on dealing with crime. For example, there is an increasing movement away from non-punitive, non-stigmatising and reintegrative strategies which they advocated in the

⁵ This refers to the rebuttable presumption that a child is *doli incapax* or not capable of distinguishing between serious wrong and simple naughtiness. Under the abolition of this rule, children over the age of criminal responsibility (10 to 13 years old) will be treated in the same way as other juveniles (14 to 17 year olds) when deciding whether or not prosecution is appropriate (Home Office, 1998a: 9).

past towards an approach of deterrence through punishment (Brownlee, 1998).

Although the adoption of the discourse 'tough on crime, tough on the causes of crime' suggests that Labour recognises that offending behaviour has its roots in social structures rather than individual pathologies, ministers and spokespersons have chosen to publicly articulate individual factors at the political level (Brownlee, 1998). In effect, the discourse has become divided into two separate discourses which have not been effectively linked either in rhetoric or as yet in practice. Policies are therefore being developed which are 'tough on crime' which have not been linked explicitly to its wider policy agendas such as welfare-to-work, social exclusion, homelessness, unemployment, and lack of services for young people (Heidensohn, 1998). For example, the document setting out proposals to speed up the punishment process for persistent young offenders focuses solely on this issue and does not engage or link this with the underlying causes of persistent offending (see Straw, 1997). Similarly, in a speech to the Magistrates Association in June 1998 on the Crime and Disorder Bill, Jack Straw outlined the main proposals contained in the Bill, but failed to articulate how these link to Labour's wider agenda dealing with social exclusion, welfare-to-work, education, and employment (see Straw, 1998). There is an implicit assumption that those who do not respond to the new inclusive strategies, such as welfare-to-work and the New Deal, will be dealt with strictly through the criminal justice system.

Drug treatment and testing orders

Another example of the new government's continuing punitive rhetoric is the introduction of drug treatment and testing orders which will run concurrently with regular probation supervision. These will differ from the treatment requirements under the 1991 Criminal Justice Act in that the courts will regularly review the offender's progress on the order and similar to prison policy, drug testing would become a mandatory component of such orders (Home Office, 1997a). The purpose of the treatment and testing orders is 'to break the links between drug misuse and other types of offending' (Home Office, 1998b: 3). The orders will be directed at offenders aged

sixteen or over 'who are convicted of crime (s) to fund their drug habit and who show a willingness to co-operate with treatment' (Home Office, 1998a: 16), who are users of opiates, cocaine and amphetamines, and who are considered to have a disproportionately disruptive effect on their communities or who persistently offend (Home Office, 1998b). Such orders will only be imposed with the 'consent' of offenders. However, if they choose not to comply, one of the options available is to impose a custodial sentence. The probation service will be responsible for the supervision of the orders and treatment providers will carry out the testing and treatment components. The Home Office will provide direct funding to probation services to purchase drug treatment (DPAS, 1999).

The new order is supposedly based upon the Miami Drug Court model which was developed in 1989 in the USA and has been shown to be successful in reducing drug misuse and reconviction (Labour Party, 1996). However, as Philip Bean (1996;1998) illustrates, this policy has not been transferred as a whole and there are important differences between the features of the drug court model and the proposed treatment and testing orders. In the States, drug courts are a slow track treatment system which was developed and led by the judiciary, rather than the criminal justice system or drug treatment agencies. American drug courts retain offenders within their control, allocate them to treatment agencies which are directed and controlled by the courts, and provide sanctions and rewards as necessary. In some states, the probation service has a role in assessing and allocating offenders to treatment while in others, probation has no role. Treatment provision is bought by the Courts and treatment professionals are employed by them. Bean (1998: 103) argues that the most important criteria of the drug court model is the court's direct control over treatment provision. The probation and treatment services cannot produce the necessary control. He suggests that in order to replicate drug courts in Britain, there would need to be more resources; legislative and structural change; a loss of independence and restructuring for treatment agencies; an increase in the number of court administrative staff; and the development of rapid response urine testing and analysis facilities (Bean, 1998).

Drug treatment providers were sceptical about the proposals for drug testing and treatment orders for a number of reasons. Coerced treatment raises fundamental ethical

dilemmas and places strains on the therapeutic relationship between treatment providers and 'clients'. Concern was also expressed about the lack of resources for treatment provision⁶. Drug agencies have always had difficulties in coping with the demand for their services and waiting lists are common (Chadwick, 1997). The orders would generate a new demand for treatment and there was a danger that existing drug agencies may not be able to expand quickly enough to meet it. Although those working within drug treatment and the penal reform lobby welcomed the diversion of drug offenders from custody, there was the danger of net-widening with the treatment and testing orders failing to be utilised as a true diversionary measure, but as an opportunity to make non-custodial sentences more punitive and tough. They may concentrate on the small-time offenders or 'minnows', rather than the 'big fish' who cause the most problems for communities. Moreover, those who test positive are also at risk of being re-sentenced to custody, thus increasing the prison population. It remains to be seen whether these fears and concerns are well-founded. The drug testing and treatment orders were piloted in Autumn 1998 with a view to national implementation in 2000/2001⁷.

These themes of continuity and change in drugs and penal policy provide the context and backdrop for the review of the 1995 prison drugs strategy and the formulation of the new strategy. These developments will be explored in the next sections.

Review of the 1995 prison drugs strategy

In September 1997, a review of the 1995 prison drugs strategy was undertaken by the Prison Service with a view to formulating a new revised strategy (HM Prison Service, 1998a). It was conducted by staff from the Prison Service Directorate of Health Care

⁶ The Government will be making an additional £40 million per year from 2001/2002 for the implementation of drug treatment and testing orders (DPAS, 1999). However, it is not clear how much of this funding will be allocated to the treatment side.

⁷ The pilots are to run for eighteen months in Merseyside, Southeast London (Croydon) and Gloucestershire Probation Services (DPAS, 1999). They are being evaluated by the Home Office and South Bank University. The government has made £1.7 million available to fund the piloting and evaluation of the orders.

and Directorate of Regimes, the Central Drugs Co-ordination Unit, and the Home Office Action Against Drugs Unit. Treatment providers and Prison Service operational staff were also consulted. The reasons for the review were associated with the appointment of the UK Anti-Drugs Coordinator, the development of the new national drugs strategy, as well as the criticisms and questions raised by the policy network in the previous phase of policy development around the balance between treatment and control within the existing strategy.

The review was informed by three pieces of research commissioned by the Prison Service. These included two projects assessing the impact of mandatory drug testing (Edgar and O'Donnell, 1998a; 1998b; Farrell et al, 1998) and an evaluation of the pilot drug treatment programmes (PDM Consulting Ltd, 1998). During the previous phase, the existence of this ongoing research had enabled the Prison Service to adopt a 'wait and see' stance and to deflect criticism away from the evolving strategy, particularly in relation to the question of possible switching from cannabis to heroin. By 1997, interest in drug misuse and other related issues in prison had expanded. In addition to the internal review by the Prison Service, there were also other committees, groups and researchers who had published reports (see Home Office, 1997b; All Party Parliamentary Drugs Misuse Group, 1998; Health Advisory Committee for the Prison Service, 1997; London Drug Policy Forum, 1997; MacDonald, 1997; Keene 1997a; 1997b; Brookes and Scott, 1998; Mair and Barton, 1998).

Nature and extent of the problem: the impact of the 1995 strategy

A judgement on the efficacy of the 1995 prison drugs strategy depends on the criteria used to measure effectiveness. Such criteria could include the proportion of positive mandatory drugs tests, the proportion of prisoners successfully completing drug treatment programmes, the number of treatment referrals, the number of drug finds in prisons, rates of recidivism and/or rates of drug misuse on release. However, the only systematic objective indicators produced through the monitoring and research commissioned by the Prison Service related to MDT results and supply reduction

measures.

As we saw in the previous chapter, one of the key objectives of mandatory drug testing (MDT) was to provide systematic data on the extent and nature of drug misuse within the prison system⁸. Evidence from the research shows that MDT had the greatest impact on recreational cannabis use. For example, the study conducted by the National Addiction Centre showed a clear downward trend in detected cannabis use across the entire prison system since the implementation of MDT, with a fall in positive tests for cannabis from 30% to under 20% during the first eighteen months of the programme. However, opiate positivity did not decrease, but remained fairly constant at a level of five per cent (Farrell et al, 1998). Qualitative research conducted by the Centre for Criminological Research at Oxford also indicated that MDT had an impact on the prevalence of drug misuse with over half (52%) of their sample claiming that they had either desisted (27%), reduced (15%) or altered (10%) their drug use as a result of MDT (Edgar and O'Donnell, 1998b: 14). Despite anecdotal evidence from prisoners, staff, the media and various reports and articles, there was no concrete evidence of prisoners switching from cannabis to heroin in the commissioned research. However, there was evidence of persistent use in relation to opiates. Thus, the researchers from the National Addiction Centre concluded that despite the amount of effort and resources which had been directed towards MDT, it had greatest impact on recreational cannabis use and little success in deterring those who may have more serious addiction problems to hard drugs, such as heroin (Farrell et al, 1998: 6).

Research also underlined other problems around the MDT procedures. Prisoners perceived the MDT process as unfair and a means of restricting cannabis use, which they regarded as a legitimate activity (Edgar and O'Donnell, 1998b; MacDonald, 1997).

⁸ Although the MDT programme produces data on the pattern of drug misuse over time, it is important to note that some misusers will inevitably escape detection. Based on self-report, it was estimated that almost one-third (31%) of current misusers had evaded detection by MDT (Edgar and O'Donnell, 1998b). Moreover, because of opiate's shorter detection rates in the urine and the relative infrequency of injecting within prisons, random mandatory drug testing underestimates the percentage of prisoners using opiates (Bird et al, 1997). This highlights the limitations in terms of the validity and reliability of the data generated through MDT and indicates that the results may underestimate the prevalence of drug misuse, particularly in relation to opiate use.

Similarly, prison staff did not see cannabis use as problematic for good order and discipline and evidence was uncovered by researchers that staff continued to 'turn a blind eye' when they found prisoners using cannabis (Edgar and O'Donnell, 1998b). Prisoners also believed that MDT had increased tension within the prison, increased their resentment of staff, led to switching to hard drugs, and made inmates more wary (Edgar and O'Donnell, 1998b; Brookes and Scott, 1998; MacDonald, 1997). Their perception of MDT was that it was used as a method of discipline and punishment, rather than a means of identifying prisoners who needed treatment (Edgar and O'Donnell, 1998b; Brookes and Scott, 1998; MacDonald, 1997). In 1996 and 1997, the Prison Ombudsman received a number of complaints from prisoners over adjudications relating to the MDT process and procedures (see Prison Ombudsman, 1997; 1998). The prisoners interviewed by the Oxford researchers were more concerned about the effect of MDT on privileges such as temporary release, parole, loss of in-cell television, and risk of being placed on closed visits than they were about the threat of additional days on their sentence. This highlighted a fundamental flaw with the MDT disciplinary system of awarding additional days which ultimately led to increases in the prison population and overcrowding. For example, the researchers estimated that for the year 1997, 159,000 days were added to prisoner's sentences due to MDT which is equivalent to 360 prisoner years. Thus, the extra prisoner days in custody can be estimated at approximately seven million pounds in additional running costs to the prison system (Edgar and O'Donnell, 1998b: ix).

Given the great emphasis placed on security in the 1995 prison drugs strategy, the impact of the Learmont and Woodcock recommendations, and the increased resources for security measures, it is not surprising that efforts to reduce the supply of drugs, such as improved perimeter security, searching, closed visits, CCTVs, targeting visitors, use of sniffer dogs, and intelligence gathering had been deemed as generally successful by the Prison Service in deterring the use of drugs (HM Prison Service, 1998a). For example, the number of 'finds' of drugs or drug implements fell from 9,503 for the period April 1995 to March 1996 to 7,587 for the period April 1996 to March 1997 (HM Prison Service, 1998a: 12). Targeting, arresting and punishing visitors to prisons was also perceived to have a deterrent effect. The number of visitors arrested for drugs-related

offences fell from 1,463 in 1995 to 1,176 in 1997 (HM Prison Service, 1998a: 14).

Although MDT and supply reduction measures were seen as generally successful in meeting their objectives, the review by the Prison Service and the evaluation by PDM Consulting Ltd⁹ of the pilot drug treatment programmes indicated that treatment provision required more fundamental improvements and changes before some of the programmes and ideas were extended more widely across the prison system (HM Prison Service, 1998a; PDM Consulting Ltd, 1998). Although there had been some expansion in drug treatment through the pilot programmes, provision remained patchy. As argued by treatment providers during the previous phase of policy development, low cost and low intensity interventions on a large-scale basis were missing within existing provision. Resources and effort had been primarily concentrated on high intensity and high cost programmes. The need to match drug treatment programmes with the needs of individual drug misusers was also highlighted. More specifically, the lack of specialist provision for certain groups in the prison system, such as women, vulnerable groups, young offenders, and those in the dispersal system was underlined. Aftercare and follow-up work was viewed as wholly inadequate and requiring immediate attention. In particular, prisons needed to initiate joint working arrangements with external agencies at the local level in order for the throughcare of drug misusing prisoners to be improved. The PDM evaluation and research in three Leicestershire prisons indicated that prison staff, both those involved in running treatment programmes and those providing support to prisoners, still lacked sufficient general knowledge about drugs and treatment and counselling issues (PDM Consulting Ltd, 1998; Hucklesby et al, 1999).

⁹The executive report on the pilot drug treatment programmes by PDM Consulting Ltd which was disseminated by the Prison Service provided a summary of key recommendations, but little detail in terms of the specific outcomes of the various treatment interventions. Questions were asked in the House of Commons regarding the publication of the full version of the report and in reply, George Howarth claimed that the report was 'intended for internal use only' and contained 'sensitive financial information about treatment services' (House of Commons Hansard Written Answers for 16 June 1998, col 188-189). However, he did provide data on the completion rates for the pilot residential programmes (34%), therapeutic communities (13%) and twelve-step programmes (49%) (House of Commons Hansard Written Answers for 16 June, col 190, table C).

Response to the problem: the 1998 prison drugs strategy

Upon completing the review of the 1995 strategy and considering the research findings, the Prison Service concluded that its basic structure - tackling supply, demand and the health consequences of drug misuse - should remain intact (HM Prison Service, 1998a: 23). The existing strategy would therefore not be subjected to a radical overhaul. In many ways, the research was used to justify the existing policy framework. However, there is evidence that some of the lessons from the research and concerns expressed by the policy network around the 1995 strategy had been taken on board. Their activities and lobbying during the previous phase had informed and influenced the reformulation of policy. The new 1998 strategy would place greater emphasis on voluntary testing; effective treatment provision; education for young offenders; throughcare; discrimination between dealers and users and between less harmful and more damaging drugs; and identifying strategies for short-term and remand prisoners (HM Prison Service, 1998b). The particular needs of women prisoners would be examined separately. However, issues relating to race remained invisible within the reformulated strategy and the particular problems of minority ethnic prisoners in accessing drug services had not been considered (see Awiah et al, 1992). Under the new strategy, there was also a commitment to develop the research base around the strategy with an emphasis on exploring recidivism rates for those participating in drug treatment programmes. Plans to develop future policy in relation to other substance abuse, particularly alcohol, were also indicated. In a report on alcohol misuse and prisons, the Health Advisory Committee for the Prison Service (1997) argued that there was an overlap between the groups misusing alcohol and those misusing other substances and advocated an integrated approach for future policy development.

Within the 1998 drugs strategy, even more emphasis was placed on partnership, liaison and co-ordination. As discussed in the previous chapter, the structural division within Prison Service Headquarters between the Directorate of Health Care, responsible for health and treatment concerns, and the Security group, responsible for security and control matters, was to be overcome by establishing a new single Drugs Strategy Unit within the Directorate of Regimes. The new unit would deal with all drugs-related issues

and bring together the various threads of prison drugs policy.¹⁰ Co-ordination and partnership would also be improved by the appointment of area drugs strategy co-ordinators who would be responsible for a group of prisons within a geographical area. Their task was to develop the strategy at the regional and local levels by ensuring consistent application of effective practice and promoting links between prisons and communities. The Prison Service was also expected to improve its representation on Drug Action Teams under the new strategy.

At the time of the policy review, members of the policy network were generally optimistic about the potential for change under the new strategy. Civil servants suggested that under the new Labour administration there was now a possibility of altering the balance between care and control. This balance would depend on their perception of the 'problem' over time:

*The current review [has been] approached with particular enthusiasm because we've got a new government and Ministers are particularly interested. It's very much interested that we've got that 'balance', as we see it at the moment, right. My guess is that it will change from time to time. We might have a new drugs strategy in a few years and we might change that balance quite considerably as our perception of the problem changes.*¹¹

They argued that the Labour government has focused more closely on the connection between MDT and treatment:

*What is particularly important and what Ministers in this administration are focusing on is that there is actually a connection between the two. In that testing is not just a punitive or record keeping initiative, but that it genuinely results in determining appropriate referrals on individuals for treatment.*¹²

¹⁰ The tasks of the unit are to report progress to Ministers and the anti-drugs co-ordinator; develop performance indicators that link to national strategy indicators; provide a focal point for the new area co-ordinators; commission research; strengthen links between the Prison Service and other agencies; monitor funds allocated to testing and treatment; provide central guidance on the commissioning and evaluation of partnership treatment interventions; develop training on drug issues; ensure that security, health and regimes remain in balance; and develop policy in relation to other substance abuse, particularly alcohol (HM Prison Service, 1998b: 8-9).

¹¹ Interview (014b) with civil servant, November 1997

¹² Interview (002) with civil servant, September 1997

Although the revised strategy was more realistic and pragmatic in its approach by targeting serious drug misuse and focusing more on treatment and throughcare, the basic punitive framework for delivering the strategy, whereby drug misusers are punished, remains in place. Moreover, there is some cause for concern around the proliferation of voluntary testing which has also been incorporated into this framework of punishment. The following sections will briefly examine the main developments within the new strategy.

Mandatory and voluntary drug testing

Overall, the new policies around mandatory drug testing (MDT) indicate a more flexible, practical and cost-effective approach. Rather than every prison testing ten per cent of its population per month, governors would be allowed to set their own levels of random mandatory testing within certain parameters¹³ (HM Prison Service, 1998a). The new strategy would also place more emphasis on promoting greater flexibility in the use of disciplinary and administrative penalties for positive tests. Where appropriate, both administrative sanctions and the incentives and earned privileges scheme could be used as responses to positive testing, rather than relying solely on awards of additional days. There would also be greater differentiation between sanctions for cannabis and Class A drugs. Whilst these developments indicate a much more pragmatic response in terms of MDT, prisoners testing positive for Class A drugs would be subjected to more frequent mandatory testing under the new strategy. This highlights the continuation of the punitive response to drug misuse. Unless prisons utilise MDT solely as a means of identifying those requiring treatment, this group will remain targeted and punished for their addiction problems.

Given the election manifesto commitment to extend access to voluntary drug testing to all prisoners by 2001, it was given much prominence in the new strategy. Since the

¹³ A minimum of five per cent and a maximum of fifteen per cent of the population within each prison would have to be tested each month.

implementation of the 1995 prison drugs strategy, voluntary testing units (VTUs)¹⁴ have proliferated across the prison system¹⁵. This can be attributed partly to the success of the VTU and treatment programme run by RAPt at Downview prison (Kinchin, 1998). The new VTUs have taken many different forms in terms of structure and operation, but they are based on the premise of providing specially designated areas for 'prisoners who agree to avoid drugs and to prove it by undergoing regular, but random urine testing' (HM Prison Service, 1998a: 17). Many of the existing units were established with very little central guidance and range from enhanced regimes and compacts to remain drug-free to relapse prevention units. The 1998 strategy seeks to issue detailed guidance to governors identifying the key issues they should consider when drawing up their own programmes for voluntary testing. A single model for VTUs would not be recommended as governors need the flexibility to adapt VTUs to the physical space of their prison and the needs of their population.

Although VTUs are popular with prisoners (Kinchin, 1998) and broadly supported by key policy players, there are a number of important issues raised by their extension across the prison system. Voluntary testing can be used as a method of assessing prisoners for greater privileges and for retaining them. Hence, differential regimes have developed on the basis of drugs use alone. If prisoners consent to voluntary tests and prove negative, then they may become eligible for privileges such as temporary release, in-cell television, desirable jobs or moving to an enhanced regime. This raises the question of 'voluntary' consent because there are penalties for those who do not consent in that they can not receive such benefits. The units have been established mainly for those who have never taken drugs and those who have given up the habit. As Hewitt (1996) argues, this has the potential to create scenarios where a recidivist armed robber who has never used drugs is better treated than a ex-heroin addict who is rehabilitated and occasionally uses cannabis. Furthermore, those who have real problems with addiction are further punished by not having access to such privileges. There are also proposals for voluntary testing and treatment units which would be targeted at Class A

¹⁴ These units are known as 'drug free' wings, but this term cannot be used officially as it would imply that the rest of the prison is rife with drugs and drug misuse.

¹⁵ By July 1998, 63 prisons within the system had access to voluntary testing in varying degrees (House of Commons Hansard Written Answers, 28 July 1998, col 101-102).

drug misusers and dealers where governors have the power to allocate these prisoners to units, thereby rendering it compulsory¹⁶. This could arguably constitute a form of punishment and also raises questions around placing users and dealers on the same programme. Drug dealers in prison are not necessarily drug users and this could create tension and increase bullying and violence. There are also issues relating to the evidential standards for voluntary testing. Mandatory drug testing is subject to national standardisation and rigorous evidential standards (HM Prison Service, 1995b), whereas less stringent procedures are often followed for voluntary testing which take place on-site and are generally cheaper, such as dip and read tests and urinalysis machines.

There are fundamental issues which need to be worked through in relation to voluntary testing and VTUs for the future. However, voluntary testing essentially means more testing and more resources¹⁷ for the increased volume of testing, staff time and training, structural alterations to the prison to create VTUs, and additional counselling provision. Because voluntary testing is inextricably linked to rewards and punishments, it cannot be considered truly 'voluntary' and it could become difficult in the future to distinguish between mandatory and voluntary testing as they appear to be merging. Furthermore, what appears to be occurring with the increased use of voluntary testing is the division of the physical space and populations within the prison on purely 'drug' lines. A director of a drug agency described this emerging demarcation and classification between users and non-users within the prison:

*There is a move now to create voluntary testing for enhanced regimes and congregate on basic regimes all the drug users and suppliers, so they'll be isolated - all the ones who want to stay on drugs and all the ones who are caught dealing. It's up to them if they want this very basic, very austere regime and almost segregated from the rest of the population. The rest of the population is going to be on enhanced regimes with voluntary testing which even though it sounds like the people who need the most help are getting the least....But it does offer a tiered response. It's giving responsibility back to the people.*¹⁸

¹⁶ Such a unit was proposed at HMP Elmley in Kent in July 1998.

¹⁷ Over the period 1999-2002, £17 million is to be spent on the voluntary testing programme (HM Prison Service, 1999)

¹⁸ Interview (015) with director of drug agency, November 1997

There is therefore a growing trend towards a bifurcated prison drugs policy with voluntary testing units and new rewards for prisoners who conform, while for those who fail to conform or are unable to regulate themselves, there is mandatory drug testing, greater surveillance and punishment.

Supply reduction

The measures to reduce the supply of drugs in prisons outlined in the 1995 prison drugs strategy were further enhanced under the revised strategy. Such initiatives were supported by the Home Affairs Committee exploring the management of the Prison Service. They recommended that security measures such as fixed furniture in visits rooms, CCTVs, sniffer dogs, random strip searching of prisoners after visits, closed visits for prisoners who have received drugs, and rigorous searching of visitors should be extended across the prison system (Home Office, 1997b). The review of the 1995 strategy highlighted various examples of good practice in relation to supply reduction and deterrence including imposing closed visits on those found guilty of drugs offences; use of CCTV recordings to provide evidence of passing drugs for subsequent adjudications; drawing up protocols between prisons and police for arrest procedures and intelligence gathering; displaying posters and newspaper articles detailing the risk of arrest and prosecution in visitors centres; and the provision of support to visitors who feel pressurised to bring drugs into prisons (HM Prison Service, 1998a). Under the 1998 strategy, the Prison Service promised 'to continue to target those who seek to profit from the misuse of drugs...we will not let up on the battle to reduce the flow of illegal drugs into prisons' (HM Prison Service, 1998b: 6-7). Three new supply reduction objectives were introduced: to develop a performance indicator on action taken against suppliers and dealers; to establish anti-social drugs-related activity as a key criterion within incentives and earned privileges schemes; and to disrupt the distribution networks for illegal drugs (HM Prison Service, 1998b).

In January 1999, supply reduction measures were further enhanced when Jack Straw

announced that visitors who were caught or suspected of smuggling drugs into prisons would be banned for a three month period from further visits (Home Office, 1999). This illustrates that the government has failed to grasp the dynamics and complexities of drug smuggling and victimisation in prison and ignored the gender dimension to the problem as outlined in the previous chapter.

Harm minimisation

Similar to the previous drugs strategy, harm minimisation measures did not receive a high profile in the policy review or the 1998 strategy. The review revealed that Health Care Standard 8 dealing with detoxification had been implemented in the pilot residential drug detoxification units, but these were found to be expensive, resource intensive, and only had the potential to deal with a minority of prisoners (HM Prison Service, 1998a). As the ACMD (1996) had warned, compliance with the implementation of Health Care Standard 8 was found to be variable across the prison system. This further highlights the enduring problem of the autonomy of prison medical officers in implementing national standards with regard to detoxification and also the continuing tension between central policy directives and local decisions about implementation. The evaluation of pilot drug treatment programmes recommended that specialist NHS services should be used to meet the need for safe and adequate detoxification and to provide specialist supervision when required (PDM Consulting Ltd, 1998). Within the 1998 strategy, two objectives related to harm minimisation were included. The first was to provide appropriate interventions within the framework of a revised Health Care Standard 8, concurrent with Department of Health guidelines, to minimise drugs-related harm. The second was to encourage close liaison between HIV/AIDS teams and those charged with taking forward the drugs strategies in prisons (HM Prison Service, 1998b).

After a long delay, research commissioned by the Prison Service which had been conducted in 1994 on HIV/AIDS risk behaviour was finally published late in 1998 (Strang et al, 1998). This involved interviews with a random sample of 1,009 prisoners in thirteen prisons about their knowledge, attitudes and behaviour concerning HIV/AIDS.

In relation to drug risk behaviour, the main finding was that the majority of drugs injectors ceased to inject on entry to prison and the rest tended to inject less frequently. However, those who continued to inject whilst in prison were more likely to share needles (Strang et al, 1998). These findings provide the 'official' evidence, which was missing during early phases of policy development, that there is a group of prisoners who continue to engage in high-risk drug behaviour and are therefore at greater risk of transmission of HIV and other bloodborne viruses such as Hepatitis C. As we saw in the previous chapter, the Prison Service recognised this threat and was developing a scheme to provide sterilising tablets for cleaning syringes to prisoners who continue to inject. The pilot scheme for sterilising tablets was introduced in July 1998 in eleven prisons for a three month period. Prisoners were to have easy access to the tablets without having to identify themselves as drug misusers. However, it is questionable given the punitive, security-focused culture surrounding drugs within the prison system whether prisoners would risk the possibility of being seen accessing the tablets.

It is interesting that no reference was made to the introduction of sterilising tablets in either the new drugs strategy or the policy review documents. It may be that the Prison Service was concerned that incorporating such an initiative into their drugs strategy document would appear as an admission of policy failure, that they were condoning drug misuse and as a contradiction to their 'tough' stance on drugs in prison. Despite the low profile of harm minimisation in the Prison Service's public discourse on drugs, key policy players felt that the new government was more willing to engage in harm minimisation debates and implement such measures. As a civil servant commented:

Politically, there's [been] a shift...in that harm minimisation was almost a banned phrase in the previous administration....Whereas I think there's much more ability to talk in terms of harmful drug misuse against a backdrop of drug misuse per se and try to make sense of what is it we're trying to tackle and where do the problems lie from a rather more informed sort of base now.¹⁹

However, the 'official' discourse around harm minimisation is likely to continue to be articulated 'privately', rather than 'publicly' for political reasons. The public face of the

¹⁹Interview (014a) with civil servant, November 1997

new drugs strategy continues to project the hard-line abstinence approach of the previous phase. Despite the greater willingness to adopt harm minimisation principles within the prison system during this recent phase, overall progress in this area remains slow and incongruent to policy and practice in the community²⁰. Reflecting on developments in harm reduction since 1988, John Strang (1998: 301) argues that the 'continued failure to use health opportunities in prisons stands as one of the resistant black spots' in the development of policy and practice.

Treatment

As argued by the policy network which emerged around the 1995 strategy and documented in the policy review and the evaluation of treatment programmes, existing treatment provision required much improvement and change to meet the Prison Service's goal of every prison having access to 'a comprehensive range of prevention, treatment and rehabilitation programmes which meet the needs of all prisoners' (PDM Consulting Ltd, 1998: 1). In order for this to become a reality, prisons would need to liaise and make treatment referrals to other prisons in their area. Under the new strategy, treatment provision was to be developed on an area basis. The new approach was based on the success of the area-wide model in Kent which established inter-prison and inter-agency co-operation through a referral system and area co-ordinator (see Appleyard, 1998).

The goal of the new strategy was to develop a drug treatment service framework which provides 'an equitable provision of basic and enhanced specialist services to meet low level, moderate and severe drug problems' (HM Prison Service, 1998a: 4). Drug services were to be configured to provide low cost and low intensity interventions across the prison system, with fewer higher cost and higher intensity programmes offered on an area and national basis. This was to be achieved through the development of an integrated counselling, assessment, referral, advice and throughcare service (CARATS)

²⁰ There is the potential for change in the longer term. Following the publication of the NHS Executive/Prison Service Working Group Report entitled, 'The Future Organisation of Prison Health Care' in 1998, two new units are to be established (Prison Health Care Task Force and Prison Health Policy Unit). One of their key aims is to facilitate greater links between the Prison Service and the NHS.

within and across Prison Service areas which would be tailored towards the specific needs of the populations in each prison (DPAS, 1999). From October 1999, CARATS were to provide a range of easily accessible interventions²¹ and act as the link between courts and prisons, different departments within an individual prison, different prisons when prisoners are transferred, and prisons and community agencies. Enhanced drug treatment services, such as residential programmes of 12-16 weeks and detoxification services, would be available on an area or national basis and therapeutic communities would be available on a national basis. Multi-disciplinary teams consisting of drug agency staff, prison officers, probation officers, health care staff and psychologists were to deliver the CARATS. A coherent training strategy on drug issues was to be developed for prison staff. The effectiveness of treatment provision was to be subject to independent research and evaluation and performance indicators on increasing treatment referrals, programme completions and reducing recidivism amongst drugs misusing offenders were to be developed (HM Prison Service, 1998b). Programmes would be subject to central accreditation and a list of accredited external providers would be established in liaison with the UK Anti-Drugs Co-ordination Unit. For the period 1999-2002, the Prison Service was to receive an additional £76 million from CSR allocations to fund this new system of drug treatment (DPAS, 1999).

Although it remains to be seen how these new initiatives will progress, the development of a universal treatment framework with its emphasis on integrating treatment between prisons and between prisons and the community had been long awaited by the policy network which had lobbied for many years for a more explicit and defined drug treatment policy. The new framework was particularly welcomed by drug service providers (see Hamer, 1998). Under this structure, they will assume more prominent roles within prison drugs policy and will enter into more formalised contractual relationships with the

²¹ These include initial assessment upon first reception; health liaison with community agencies on reception; specialist input into pre-sentence reports, bail applications, sentence planning and assessments for home detention curfews; post-detoxification assessment and support; counselling aimed at addressing drug problems; support and advice on a range of drug, welfare, social and legal issues, including harm minimisation; assessment for in-prison and post-prison rehabilitation programmes/drug services; pre-release training; health liaison with community agencies upon a prisoner's release, and liaison with and referral to community agencies to enable effective resettlement. Although there are to be specialist detoxification units in some prisons, most prisoners would receive medical detoxification on an outpatient basis. (DPAS, 1999: 27-28).

Prison Service. A mutually dependent exchange relationship has emerged whereby the Prison Service has become dependent on outside drug agencies to develop and implement the treatment strand of the strategy, while the treatment providers have become dependent on the Prison Service for large and often lucrative contracts. This has altered and reshaped the traditional policy networks around prison drug issues. Drug treatment agencies have moved towards the core of these network structures, rather than operating on the periphery in more independent roles. Under the new framework, it is unclear as to which group will lead drug treatment in prisons. The key question is whether treatment will be led by prison management or by service providers? Although the previous arrangements were often ad-hoc and informal, drug agencies working in prisons did have a certain degree of autonomy to determine their own styles and methods of working.

The danger involved with these new formalised partnerships between drug agencies and the Prison Service is that they could lead to some agencies becoming 'incorporated', losing their independence and critical stance, and compromising their underlying ethos, values and philosophies. A director of a penal reform group offered an alternative view of partnerships arguing that they are often dangerous, particularly where prisons are concerned, and that the Home Office had successfully incorporated parts of the voluntary sector into the punitive framework of the prison environment.

...the Home Office has successfully incorporated the voluntary sector. I wish the voluntary sector could be renamed the independent sector because the independence is crucial...So you call it partnership. I call it incorporation. It's a scary thing...the emulation of one group by the other.²²

Impact and influence of prisons drugs policy

The development of prison drugs policy has been affected by shifts in the wider social, political and policy context. However, by the late 1990s, there is also evidence that the

²²Interview (029) with penal reformer, February 1998

reverse process was occurring with many of the ideas, initiatives and practices within prison drugs policy influencing the way in which subsequent drugs policy has been shaped. These include greater acceptance of coerced treatment by policy-makers and practitioners; increased emphasis on the criminal justice system as an arena for drug treatment; and the proliferation of testing across other areas. The developments within prison drugs policy have laid the foundation for a much more punitive and coercive system around drugs and drug control.

Coerced treatment has become accepted almost universally within policy debates. Similarly, there appears to be a sea change in terms of the willingness of treatment providers to work within the criminal justice system. As we saw in previous chapters, drug agencies had been reluctant to accept referrals from the criminal justice system in the past due to the coercion involved. Because of the new resources being made available for drug treatment, new opportunities are now available for drug agencies and many now have an interest in pursuing contracts within the criminal justice system. Concern was expressed that treatment providers had compromised their principles by working with prisoners who were not entering treatment on a voluntary basis. Key policy actors maintained that in order for treatment to be effective, it had to be entered into on a voluntary basis. As a penal reformer argued:

*You've got the voluntary sector with their vested interests and all their jobs, and their monies and their fundraising. They shouldn't work in prisons where prisoners are punished...They've swallowed a lot of the principles. Drug groups used to argue that they wouldn't take anybody in a rehab unless it was voluntary and they were committed to the programme. Now they're working with people in prisons who are so-called committed to the programmes, but if they have a relapse or found with drugs in their urine, they're sent down the plonk or they lose their remission.*²³

On the other hand, the view emerging from the service providers was that they no longer had the luxury of dealing with voluntary clients:

Most drug treatment services are being impacted to a greater or lesser extent by coercive drug treatment. You've got the Crime and Disorder Bill

²³Interview (029) with penal reformer, February 1998

*with all the testing and treatment orders coming up. There's going to be a whole load of proposals coming out in the New Deal around employment where one of the ways to avoid employment is to say that you're dealing with your drug problem. So we're sort of coming in from the cold, if you like. We used to have the luxury of being entirely voluntary. People arrived here if they wanted to and we talked to them. That luxury doesn't exist anymore.*²⁴

The criminal justice system as a whole was increasingly being seen as having much potential in terms of a location and opportunity for drug treatment. At each stage of the criminal justice process - arrest, court, sentencing, probation, prison, and parole - drug treatment was to be developed and provided. In many ways, British drug treatment appears to be moving towards an American model of service provision where providers are diverted from their work in the community and the criminal justice system becomes the 'front end' of treatment. A director of a drug agency described this shift in the following terms:

*A lot of the treatment services are now linked to the criminal justice system, so in a sense the criminal justice system has become the 'front end' of treatment services...Now, services are actively engaging with prisons and the criminal justice system...So those groups are now more closely aligned with one another. A lot of it has to do with the flow of the money, but it actually reflects what is happening in the American approach...There [are] dangers in having the criminal justice system at the front end of treatment...Drug agencies need to be quite cautious about their relationships with the criminal justice system. There are benefits. There is the potential to meet the needs of individuals. We also need to think about global consequences of that and what it says about their role in relation to users. Basically I still believe that it is better if people who have got drug problems make decisions on their own to seek help and treatment.*²⁵

With the new emphasis on treatment within the criminal justice system, there was a real danger that offenders would be sentenced to prison and other community penalties with drug treatment options in the hope that they would receive help for their drug addiction problem, rather than as punishment for their offence which may not warrant such a severe sentence.

²⁴Interview (026a) with director of drug agency, January 1998

²⁵Interview (003) with director of drug agency, October 1997

Mandatory drug testing also has its antecedent within the prison system in Britain. The new treatment and testing order is the most obvious example of transferring prison policies to community penalties. Similarly, at the Labour Party Conference in September 1999, the government announced its plan to introduce mandatory drug testing in police custody for suspects arrested for criminal offences. Those who test positive for opiates or cocaine will be denied bail. By the late 1990s, drug testing had generally become accepted by policy-makers and practitioners as a key mechanism within drugs control policy. There was a clear consensus amongst those most involved in drugs policy development that testing would continue and spread into other spheres of social life, including education and employment.

The development of drugs policy in prisons has also affected penal policy and regimes. Drugs had assumed a high priority within the prison system at a time when other programmes were being cut back. This impacted upon the treatment programmes in prison in that drug workers were often having to deal with a range of other problems presented by those undergoing treatment. However, the priority given to drugs was subject to change and was contingent upon how much of a security problem it remained within the prison system. Because drugs were seen to be connected to issues of order and control, they had been given more attention. As a director of a drug agency commented:

*They're still juggling and there's a number of plates spinning at the moment and drugs is becoming a bigger plate and it spins faster and it looks like it's going to fall more frequently so they have to keep giving it attention. Whether it becomes a greater priority depends on how much of a major security problem it is. That will be the driving force. They risk losing control of the prison environment through drugs and they certainly have come close to that. That's not about health care, it's about maintaining control of the prison.*²⁶

Similarly, drugs in prison has remained an important political issue under the Labour government which appears committed to continuing Michael Howard's punitive zero

²⁶Interview (028) director of drug agency, January 1998

tolerance campaign. This political commitment may also change, but in the current phase of policy development, drugs policy in prison has remained high profile and impacted upon wider policy development and agendas.

Conclusion

This phase of policy development continues to evolve and it remains to be seen how the new strategy will develop in practice, but it is possible to reflect on the significance of some of the proposed changes. Although some of the recent policy developments represent a new 'realism' in responding to the drugs 'problem' in prisons, the underlying punitive framework remains within the new strategy. This 'realism' is characterised by the increasing recognition that the drug problem cannot be fully eradicated, the commitment to evidence-based policy and practice, and by new government interest in attempting to rectify the balance within the strategy towards the treatment end of the continuum. It is clear that some of the criticisms that the policy networks have raised around drug issues in prisons over the various phases of policy development have been considered and taken on board in the new strategy.

There has been some attempt to contain and manage the increasing contradictions between treatment and punishment which emerged during the previous phase. This is illustrated by the emphasis on improving treatment and throughcare provision, the issuing of sterilising tablets to prisoners who continue to inject, the differentiation between hard and soft drugs, the partial relaxation of MDT procedures and the increasing recognition of alcohol in policy development. However, at the same time, responses which emphasise 'punishment' and 'control' have also been further improved and enhanced and run parallel to the more liberal response. The focus on testing, whether it be mandatory or voluntary, has continued. Similarly, supply reduction and security measures have been strengthened. The official discourse remains focused on 'control', 'order' and 'punishment' and these are the discourses which are often articulated publicly. Moreover, the policy network around drug issues in prisons has been reshaped during this phase. Drug agencies have entered into more formalised

partnerships with the Prison Service and moved from the periphery toward the core of the policy networks. The key danger for future policy development is the 'incorporation' of this important sector of the policy network and the silencing of a critical voice in prison drugs policy.

One of the most significant developments at the turn of the millennium is the influence that prison drugs policy has had on overall policy development. The proliferation of drug testing in community penalties and other initiatives, the almost universal acceptance of coerced treatment and the criminal justice system moving to the 'front end' of treatment provision are all indications of the impact, influence and power of the developments in prison drugs policy and practice. In many ways, as Cohen (1985) has argued, this represents the dispersal of control and the blurring of the boundaries between the prison and the community, setting the stage for future policy developments.

Chapter Seven

Conclusions

Containing and managing contradictions: shifting agendas and policy networks

Introduction

This thesis has been concerned with exploring the key developments within English prison drugs policy in the late twentieth century. The study has illustrated a growing contradiction between treatment and punishment within policy development which has become more intense, acute and difficult to contain and manage over time. In response to this contradiction, a significant shift has occurred from a situation of 'no policy' to a much more explicit and defined prison drugs policy. The first phase of policy development was characterised by policy which was implicit, unstated, informal, private, and internal. During the second phase, there was a move towards more formal, documented policy, taking the form of loose guidelines which were subject to local variations in implementation. The last two phases were characterised by policy which was much more explicit, formal, public and overt compared with the previous phases.

Policy networks have played central roles in shaping and re-shaping this policy development, particularly in terms of their attempts to contain and manage the tension between treatment and punishment. Their activities have been influenced by shifting frames and definitions of the drug problem in prisons, by research, evidence and knowledge and by the wider policy, political and social contexts. This chapter concludes the thesis by reconsidering the development of prison drugs policy from 1980 in light of my original research questions which are interlinked. I begin by addressing my first principal research question: how influential have the policy networks around drug issues in prisons been in the development of policy? When have they been most influential and why? I then examine my second question: how have these networks attempted to contain the contradiction between treatment and punishment in policy development? Finally, I address my third question: how has this 'containment' been shaped by changes

in the way in which the drug problem has been framed and defined, by new research, evidence and forms of knowledge, and by the impact of the wider political, policy, social and institutional contexts? I conclude the chapter by discussing the significance of my findings for the future development of prison drugs policy.

The role and influence of policy networks

It is evident that the policy network concept has relevance and value in examining the interaction between the various actors involved in the development of prison drugs policy and how these relationships have shaped policy outcomes. The conceptualisation of policy networks offered by Wilks and Wright (1987) has proved most useful in my analysis as it stresses the need to disaggregate to the sub-sectoral level of policy and enables researchers to explore how developments within wider policy sectors affect sub-sectors. Prison drugs policy occurs at the sub-sectoral level or at the interface between penal and drugs policy and is influenced by developments in these two policy areas. The Wilks and Wright model is also issue-based, making it more flexible and dynamic compared to other static alternatives. Policy networks form around issues which change over time. In the case of prison drugs policy, different policy issues, problems or functions have provided the occasion for the formation of policy networks. In the first phase of policy development, throughcare and release was the key policy issue, which was followed by HIV/AIDS, then by mandatory drug testing and treatment provision, and finally by the review and reformulation of the 1995 prison drugs strategy (see Table 7.1). These shifts in focus illustrate the dynamic nature of the policy process. Many of the policy issues have been generated exogenously or by external pressures such as HIV/AIDS and the increasing influence of US policies. Policy networks have therefore operated mainly in a reactive way. Policy issues have shaped the formation of policy networks and through their activities, these networks have further shaped and defined these issues.

Table 7.1 Policy issues and policy outcomes in prison drugs policy

KEY POLICY ISSUES		POLICY OUTCOMES
1980-1986	Throughcare & release	Service development (Parole Release Scheme)
1986-1993	HIV/AIDS & drug misuse	1987 Statement on throughcare of drug misusing prisoners 1991 Caring for drug users manual Policies on HIV/AIDS
1993-1997	MDT (mandatory drug testing) & treatment provision	1995 prison drugs strategy (MDT, increased security measures, & pilot drug treatment programmes)
1997-	Review & reformulation of the 1995 prison drugs strategy	1998 prison drugs strategy (move towards voluntary testing & more comprehensive treatment provision)

Depending on the issue at the centre of policy development, membership within the policy networks has changed and adapted over the phases. As drug issues in prison gained more prominent positions on the policy agenda, interest in this area expanded and more players became involved in the policy process. Some members however have had long histories of involvement and have been consistently represented over the various phases, including civil servants within the Prison Service and some drug agencies such as the Parole Release Scheme. In particular, the Prison Service has played important gatekeeping roles within all the policy networks which have emerged. Various committees such as the ACMD, the House of Commons Social Services Committee, and Home Affairs Select Committee have also played key roles in shaping policy and often their membership overlaps with the networks. In order to gain access to the policy process, groups have tended to present themselves in a conservative, rather than radical light. For example, many of the drug agencies involved advocate abstinence publicly, but privately promote harm reduction practices within the prison environment. Similarly, penal reform groups would not present themselves as overtly 'abolitionist'. As Ryan (1978) argues, such groups need to be seen as 'acceptable' to government.

In the first phase of policy development, the work of the ACMD (1980) and Social Services Committees (1985;1986) served to initiate a small policy network around throughcare and release issues for drug misusing prisoners. Although the Home Office

and the Prison Medical Service occupied central positions at the core of this network, the negotiation and planning by SCODA, NACRO, the probation service and various drug agencies was instrumental in ensuring that a service was developed for drug misusing prisoners on release during the early 1980s. In the second phase from 1986 to 1993, the advent of HIV/AIDS widened interest in prison drug issues, bringing new players into policy networks including more drug treatment agencies, medical professionals, penal reform groups (eg. Prison Reform Trust), professional associations (eg. ACPO, NAPO, POA), social researchers, HIV/AIDS organisations, and health authorities. During this period, the ACMD also sought to influence the policy process by producing three influential reports on drug misuse and AIDS which covered the penal system (ACMD, 1988; 1989; 1993). Although civil servants in the Directorate of Prison Medical Services were the key state actors involved at the core of this network, the power of the Prison Medical Service became diluted over time as more agencies gained access to policy networks and to prisons to work with drug misusers.

By 1993, interest in prison drugs policy further increased and the shift towards partnership and multi-disciplinary approaches brought more players into the process. The increasing contradiction between treatment and punishment within policy development led to an increase in the number of representatives within the fields of drug treatment, penal reform, civil liberties and research. These groups were involved in lobbying against the introduction of MDT and for more comprehensive treatment provision. Interest in this area also expanded within the state. As drug issues in prisons became increasingly politicised, the Home Secretary and Director General of the Prison Service began to occupy powerful positions within policy development. Civil servants in the Security Group and Health Care Directorate of the Prison Service and the Central Drugs Co-ordination Unit were also involved at the core of the network. However, this is not to suggest that the Prison Service was unified in their interests around policy. There were structural and philosophical divisions between the Health Care Directorate and Security Group which led to the control and treatment elements of the 1995 strategy developing separately. By 1998, the Prison Service Drugs Strategy Unit was established as an attempt to overcome these divisions and unite policy interest. This unit is likely to remain at the core of any future policy networks around drug issues in prisons. With the

greater emphasis on treatment and the growing interdependence between the Prison Service and service providers, drug agencies are also likely to move from the periphery towards the core of future networks.

The role, influence and power of policy networks within the policy process has varied over the different phases. Over time, they have shown an ability to identify opportunities at key moments, articulate their ideas and respond to agendas within the constraints, pressures and limitations of the wider policy, political, social and institutional contexts. They have been successful in challenging and changing perceptions, policy and practice. Through this process however, parts of the policy network have been drawn in and incorporated by the state, losing their independence and capacity for criticism. In the first two phases of development, policy networks played central roles in drawing attention to drug issues in prison and placing these on the policy agenda. In particular, their main concern was the way in which drug misusing prisoners were treated and the lack of congruence between the provision in prisons and that in the community. These networks were instrumental in helping to expose the drug problem in prison and pressing the Prison Service both to acknowledge the problem and to develop more explicit and humane policies. During the early stages, policy development was therefore driven by external interest, emanating from below or from the fringes of policy networks with drug agencies, professional associations, and penal reform groups playing key roles. Their success is illustrated by the development of specific services for prisoners in the first phase of policy and by the formulation of guidelines for their treatment and throughcare and the cautious HIV policies which emerged during the second phase (see Table 7.1).

In the last two phases of policy development however, policy networks have not been as powerful in terms of activating the agenda and contributing to the initial stages of the policy process. Instead, they have responded to an agenda determined by politicians. As in other policy areas, the increasing shift towards the populist punitive and managerial discourses led to less consultation between government and experts during the 1990s. Outside groups did not have the same opportunities to influence policy development (Rock, 1995; Downes and Morgan, 1997). Although they lost control over the agenda, the networks around drug issues in prisons adapted to these new circumstances. Under

the punitive drugs policy framework which emerged from 1995 with its focus on mandatory drug testing and security measures, the contradiction between treatment and punishment became much more acute and pronounced. In response, the policy network attempted to lobby against the introduction of MDT. However, given the statutory powers surrounding the testing procedures, these attempts proved futile. The service providers recognised this and turned this into an opportunity to argue for an expansion of treatment within prisons to rebalance the strategy. Their success can be seen in the pilot drug treatment programmes which emerged during the course of the 1995 strategy and in the greater prominence given to treatment under the revised 1998 strategy. There is evidence that some of their criticisms around the 1995 strategy were taken on board and infiltrated the new policy agenda which emerged in 1998.

Since 1980, drug treatment agencies have remained important players in policy networks. In the latter phases of policy development, the Prison Service increasingly recognised that it needed these agencies to develop and provide drug treatment programmes in prison and therefore allowed them greater access to the policy process. Similarly, the Prison Service provides the drug agencies (many of which previously had insecure contracts or no contracts at all), with security, stability and a source of longer-term funding. Under the new CARATS (counselling, assessment, referral, advice and throughcare service) framework, this mutually dependent exchange relationship has been reinforced further. In the most recent phase, the policy network has therefore changed shape. Over time, it has evolved from a structure which was diffuse and informal to one which is more identifiable, formal, concrete and institutionalised. In a sense, some drug agencies have moved from operating in independent roles on the periphery of policy networks towards being fully 'incorporated' into the core of these networks. They now have a stake in the continuation and expansion of the current policy framework. Given their vested interests and dependence on the Prison Service in relation to contracts, it remains to be seen whether these agencies will continue to play such central roles in lobbying for change and reform in prison drugs policy in the future. As their relationship with the state becomes more formalised and concrete, the danger is that a prominent voice in prison drugs policy will be silenced.

The activities of the policy networks in shaping policy development and containing contradictions have been influenced by various interrelated factors including how the drug problem in prison has been framed and defined, the role of research, evidence and knowledge, and the impact of shifts in the wider contexts and other policy subsystems. The relative influence of these factors will be assessed and considered in the next sections.

The impact of frame shifts

The way in which the drug problem in prison has been framed and defined has shifted over the phases of policy development. This has had a profound influence upon the policy options considered and the types of policy adopted and implemented. Policy networks have played key roles in the processes of identifying, defining and framing policy issues. However, the ‘institutional embedding’ of the different policy players has influenced these processes. There are important differences related to the different structural locations and ideological foundations of the various groups involved. Moreover, the framing process has not only been influenced by the reactions, perceptions and experiences of those involved in policy networks, but also by real pressures such as increases in drug addict notifications by prison medical officers and the number of drug offenders sent to custody as well as by the results of mandatory drug testing. In considering the naming and framing of policy issues over time, four key frame shifts can be identified.

In the first phase of policy development, the framing of the drug problem in prison was hindered by the lack of evidence around the issue. The collusion and secrecy around drugs during this period also inhibited the framing process as the Prison Service was reluctant to admit that there was a drug problem in prisons. In terms of official statistical indicators such as drug addict notifications and drug offender statistics, the drug problem within the prison population was increasing. For those who came into the prison system with a drug addiction, this was seen as an individual problem to be dealt with clinically by the Prison Medical Service. As we have seen in the previous chapters, the discourse of

less eligibility has operated in the case of drug treatment and care in prisons. Prisoners have not generally had access to the drug treatment techniques, such as long-term detoxification, available in the community. During this early phase, the prison population was defined mainly by the Prison Medical Service as undeserving and unworthy of humane drug treatment and detoxification provision. Given the collusion and various constraints at this time, a prudent way to frame the problem of drug misuse was to focus on the throughcare and release aspects or the external dimension of the problem, rather than framing it as an internal problem for the Prison Service. The policy network was aided in this framing by the ACMD report which had recommended better throughcare provision for drug misusing prisoners (ACMD, 1980).

During the period 1986-1993, the HIV/AIDS crisis and fears of transmission into the 'general' population were the precipitating factors in the reconceptualisation of the drug problem in prison. Drug issues and policy development took on a new urgency. This crisis along with the growing research and evidence base and the increase in incidence and severity of the drug problem meant that the collusion and denial around drugs in prison could not be sustained. The policy network which had formed around HIV and drug issues framed the problem in terms of the threat to public health and advocated the adoption of the harm reduction policies which were being pioneered outside the prison walls. Although the Prison Service recognised the public health dimension, they disagreed that a policy solution based on a 'radical' harm reduction strategy was appropriate within the prison environment.

By 1993, there was a further shift in how the drug problem in prison was conceptualised. On the whole, drugs were increasingly framed by the policy network and politicians as a problem for the institution rather than for the individual and as an enforcement rather than a health problem. There was the perception that the drug problem was leading to a loss of control of the prison environment. This was reinforced by further increases in the drug addict notifications and drug offenders in custody as well as by the preliminary MDT results which showed a significant number of prisoners using drugs within prisons. It was also linked to wider drugs and penal policy development which had become more enforcement focused. However, there was a lack of consensus regarding the drug

problem in prisons during this phase. Those within the traditional caring roles, including drug workers and probation officers, continued to express the problem in individual, health-related terms, rather than institutional, enforcement-related terms. However, drugs were also seen as a problem which needed to be managed and contained. Fed by the populist punitive rhetoric during this period, the framing of the problem which emphasised the institutional, control and enforcement aspects dominated, leading to the strategy in 1995 which included MDT and increased security measures.

In the recent phase, the policies and procedures adopted in 1995 created 'second generation problems' which formed the basis for new policy responses (Spector and Kitsuse, 1977). For example, elements of the policies themselves, many of which had been highlighted by the policy network, such as the inflexibility of the MDT procedures, lack of treatment provision, and the imbalance of the 1995 strategy were framed as problems which needed to be rectified. Under the 1998 strategy, there was an attempt to redefine and rebalance the strategy towards treatment, but at the same time the discourses and initiatives around security and punishment were also strengthened.

The framing of the drug problem in prison has mirrored the growing contradiction between treatment and punishment in policy development. It has broadly shifted from emphasising the health and treatment related aspects of the problem to highlighting the security and control dimensions. This shift has been influenced by increases in the extent of the problem and the wider political and policy context which has increasingly focused on enforcement and punishment. Operating within these constraints, policy networks have nevertheless been influential in framing drug issues in prisons and in their attempts to contain the contradictions between treatment and punishment.

The role of research, evidence and knowledge

Although research has not been a primary factor in policy decisions, it has nonetheless played a role in the development of prison drugs policy. As policies have become more explicit and defined over time, research and evidence have become increasingly important

in the policy process. In Chapter One, I outlined the various models of research utilisation put forward by Carol Weiss (1986). Under her framework, it is clear that research in the context of prison drugs policy development has not corresponded to either the knowledge-driven or problem-solving models. In this particular case, the application of research to policy has not been direct, specific or linear. Research has not directly influenced policy choices or decisions by providing evidence, information and knowledge to help to solve particular policy problems. The underlying assumption of these models is that policy is formulated through a rational, orderly process and that research will directly inform this development. However, research is only one element in what is essentially a non-rational, political process characterised by competing influences and claims (Brownstein, 1998). The role of research, evidence and knowledge has varied over the phases of prison drugs policy and the enlightenment, interactive, tactical, and political models can be identified within this development.

In the first phase from 1980 to 1986, there was virtually no research or evidence documenting the extent or nature of the drug problem in prison. In fact, there was very little criminological work on drug issues until the late 1980s (Berridge, 1990; Pearson, 1990; South, 1997). The collusion around drug misuse in prison during this phase meant that research access was virtually impossible to negotiate (Pearson, 1990). This lack of research had an impact on policy development in that in the absence of any evidence of a drugs 'problem', it justified a policy of 'no policy' or one which was internal and hidden from outside scrutiny. Although the models put forward by Weiss do not allow for such circumstances, it is evident that just as research may have an impact upon policy, so too does the *absence* or *lack* of research.

By the early 1990s, this situation began to change with the HIV crisis. Researchers finally managed to gain limited access to conduct research, enabling them to begin to explore some of the problems associated with drugs and high-risk behaviour within the prison environment. Over time, research, evidence and knowledge began to accumulate which assisted the policy network around HIV and drug misuse in exposing the drug problem in prison, challenging the view that it was insignificant and pressuring the Prison Service for a more liberal and humane response. In effect, this evidence base helped to

sensitise policy-makers to the drug issue in prisons and turn what was perceived as a 'non-problem' into a 'problem'. The way in which research was utilised during this phase corresponds most closely to the *enlightenment model* or indirect diffusion (Weiss, 1986). Under this model, diverse pieces of research, evidence and data build up over time which help to expose and define social problems and place these issues on the policy agenda. The *interactive model* of research utilisation can also be identified whereby research findings, information and knowledge are pooled together by a range of actors including civil servants, politicians, interest groups, journalists and practitioners in order to define and make sense of the problem. It is clear that this increasing evidence and knowledge base around drug issues in prison played an important role in pushing forward policy development during this phase.

In the next phase 1993-1997, research utilisation corresponds most closely to Weiss' *tactical model*. In the face of increasing criticism from the policy network around the balance in the 1995 prison drugs strategy, the overemphasis on MDT and the possibility of switching to Class A drugs, the Prison Service commissioned both quantitative and qualitative research to evaluate and monitor the MDT policy and procedures. As we saw in Chapter Five, the existence of this 'research in progress' allowed the Prison Service to buy time and to deflect attention away from the evolving strategy. In this sense, research was used as a 'tactic'. However, it was not only the Prison Service which was interested in research and evidence. For example, the data generated through the initial MDT results was used by the drug agencies to argue for an expansion of treatment provision. In the most recent phase, the results of these commissioned pieces of research provided justification for leaving the basic structure of the 1995 strategy intact and for policy changes which were already underway such as the moves towards voluntary testing. In this sense, the contribution of research to the formulation of the 1998 prison drugs strategy most closely corresponds to the *political model* whereby research plays a legitimisation function for particular policy decisions and serves to confirm existing arguments. However, research and evaluation was also used in a more direct way to change future policy around drug treatment and throughcare provision and to develop more comprehensive drugs training programmes for prison staff.

The increasing interest in drug issues in prisons and subsequent policy development have also influenced the research agenda. The new policies have generated both commissioned and independent research on drug issues within the penal system. Compared with the first phase of policy development in the early 1980s, there has been a proliferation of studies on drug issues in prisons and the criminal justice system. Policy interest and development in this area has therefore impacted upon the research agenda. This interaction between research and policy illustrates the complexity and reflexivity of the relationship between the two areas. Despite the increase in drugs research in prisons, it remains a difficult and sensitive area to access and study. Research commissioned by the Prison Service is more likely to be considered by policy-makers and therefore more likely to have an impact upon policy than that which is independent and external to government. Similarly, in-house researchers or those who speak the language of government, deliver the goods on time, understand the structures, procedures and processes involved in research and policy-making, and who are unlikely to 'rock the boat' are more likely to have influence in the policy process than those who do not hold these characteristics or are unwilling to conform.

The political, economic and social context of research utilisation has been important during this period of policy development. It is clear that the dominance of the managerialist model has influenced the types of research and researchers which are favoured, commissioned and used by government. The growth of what Jock Young has termed 'administrative criminology' has paralleled the developments in managerialism. This type of criminology is characterised by a lack of concern with aetiological debates about crime in terms of social justice and a preoccupation with technology and control (Young, 1986: 12). The type of research which fits into this context focuses on the 'management' of the criminal justice system. It is generally quantitative in the form of evaluations, audits, and surveys, emphasises inputs, outputs, throughputs, monitoring and efficiency, and produces statistics or measures of performance and clear recommendations for action and intervention (Pollitt et al, 1992). In the case of prison drugs policy, the concern of much of the research has been on the rates of positive MDTs and the incidence of switching to Class A drugs. The focus has therefore been on *what happens* rather than on the meanings, choices or behaviours associated with drug

misuse or *why* prisoners begin or continue to use drugs in custody. In the future, the focus of research is likely to extend to completion rates for treatment programmes and recidivism rates for drug misusing prisoners.

Under the new Labour government, 'evidence-based' approaches are being emphasised in all spheres of policy. This shift attempts to ensure that practitioners use methods which have been found to be effective rather than the ones they prefer. In theory, such an approach would also ensure that the various performance indicators and monitoring exercises would not be an end in themselves, but used to inform practice. James and Raine (1998: 100) identify two key dangers with this approach. First, it attempts to achieve rationality and prescription in a context of complex questions and dilemmas, rather than answers and decisions. Second, it emphasises proof and action that can be delivered in a context of aspirations and uncertainties. With the continuing emphasis on management, performance and monitoring systems, evidence-based approaches under these conditions are unlikely to be sufficiently flexible, adaptable or sophisticated to explore and probe the underlying causes of drug misuse and crime. Thus, there will continue to be a preoccupation with questions of technology and control.

The impact of shifting contexts and terrains

The work of the policy network in the process of framing drug issues in prisons and advocating their solutions has been influenced by and occurs within a wider context. As outlined in Chapter One, Rein and Schon (1993) put forward the idea of 'nested contexts' which can be broken down into internal, proximate, macro, and global contexts. This framework is useful because it illustrates the complex process by which policy issues overlap and interact with wider issues, contexts and policy solutions. In the case of prison drugs policy, the framing and reframing of the drug issue in prison and the development of policy has occurred as the four nested contexts shift and impact upon one another.

The *global context* of prison drugs policy refers to changes at the broadest level affecting

policy development. At this level, the rise of New Right ideology with its emphasis on neo-conservative politics and neo-liberal economics has influenced all sectors of public policy. The contraction of the welfare state has been accompanied by an expansion of the penal complex (Hudson, 1993). Through a systematic comparative analysis, Weiss (1998) argues that the world recession of the 1970s represents the turning point in post-war penalty towards an increasing punitiveness with world-wide increases in imprisonment, sentence lengths, and severity of penal regimes. During the 1960s and early 1970s, there was a clear consensus amongst penal practitioners and commentators regarding the correctionalist framework which was based on notions of reform, treatment and rehabilitation. As David Garland (1999: 8) argues, such a consensus no longer exists as the old penological frameworks have disappeared and new ones have not yet emerged to replace them. Penal policy and institutions are therefore in a state of transition between different policy regimes. Within this uncertainty, a number of converging penal trends in the western world are identified by Garland (1999: 8): erosion of correctionalist ideologies; shift to expressive justice and punitive measures; return of the victim; emphasis on public protection; management of risk; changing objectives of community penalties and custodial institutions; politicisation of penal policy discourse; commercialisation of penalty and the drift towards mass imprisonment. Most, if not all, of these penal dimensions can be applied to the development of prison drugs policy in the British context.

A related development has been the increasingly common practice of importing or transferring policy ideas and procedures, particularly from the United States. In the UK, this has become a trend in many areas of public policy, occurring under both the Conservative and Labour governments. For example, private prisons, boot camps, electronic monitoring, 'prison works', and 'three strikes and you're out' sentencing policies have their antecedents in US penal policy. This trend is not just evident within the UK, but in other countries such as Canada (see Roberts, 1998). Garland (1999: 7) observes the growing 'internationalization in penal matters [which] ensures that purportedly successful (or merely popular) policy measures emerging in one context will quickly be emulated elsewhere'. Given the drift towards mass imprisonment in the United States, it seems absurd to look to the US for policy ideas. As Jock Young (1997b: 39)

so aptly comments, 'to attempt to learn crime control from the US is rather like travelling to Saudi Arabia to learn about women's rights'. Similarly, various commentators argue that the US 'war on drugs' has been exported to other nations (see Ryan, 1998; South, 1998; Stares, 1996). This has resulted in the development of a punitive and prohibitionist global discourse around drugs as opposed to a treatment, public health oriented one. In the UK, the 1995 prison drugs strategy was heavily influenced by the US drug testing and abstinence-based treatment programmes. The appointment of an American-style drugs czar and the introduction of the new treatment and testing orders based on the US drug court models are also key examples of policy transfers.

The *macro context* of prison drugs policy refers to changes in the overall direction of policy and the influence of wider social, political, economic and institutional change. The managerial reforms and restructuring implemented by the Conservative governments from 1979-1997 have transformed the public sector beyond recognition. Moreover, the managerialist trend has continued, if not intensified under the new Labour government. The 'new public management' with its emphasis on performance, value for money, privatisation, partnership and community has successfully penetrated all areas of public policy. Although the shift towards managerialism within the criminal justice system occurred later compared to other policy areas, it was not immune from these pressures. One of the ways to manage the emerging uncertainty and contradiction within the penal system has been to apply managerial techniques, rather than to engage in debates around penal values and ideology. The three Es – economy, effectiveness, and efficiency – began to manifest themselves in prisons during the late 1980s. As we saw in Chapter Four, particular examples include the overhaul of working arrangements for prison officers and management structures under the Fresh Start initiative in 1987 and the introduction of two private prisons in 1989. By 1993, managerialism within the prison system had culminated in the Prison Service becoming a Next Steps agency. This involved a greater distinction between operational and policy matters, greater emphasis on 'strategic' planning with the formulation of corporate and business plans, the development of performance indicators and greater emphasis on co-ordination and partnership within the criminal justice system. Drugs policy has also been influenced by

the managerial discourses of performance and partnership. This can be seen most clearly in the 1995 and 1998 drugs strategies with their emphasis on action plans, performance indicators, audits and evaluations, and partnership and co-ordination structures.

Managerialism has forced the development of a prison drugs policy which is much more explicit and can be measured. This shift corresponds with the growing patterns of conflict, contradiction and convergence between treatment and punishment and can be seen as an attempt to manage these tensions. Managerialism and its associated techniques create a myth of rationality, planning and control within policy-making. However, key players within the policy process argued that the development of prison drugs policy should not be viewed as 'rational' in any sense. In particular, the 1995 drugs strategy was perceived to be the result of a number of issues which coalesced into a policy, rather than the result of a systematic process:

Though it is now presented as the Prison Service drugs strategy, I'm not sure it was actually conceived as a 'strategy'. There were different strands that coalesced into something...It's never as clean and as neat and as rational as sometimes in hindsight you like to present it.¹

Similarly, policy development was compared to a process of 'osmosis' and as a reactive, rather than a proactive process:

If one is looking at policy development, it's a process of osmosis, rather than anything else sometimes. There aren't too many think tanks going on in the [department]...There are bits of research, reports which come out of incidents or catastrophes - a prison breakout, a death, or several deaths close together. Then we develop a policy on security or how to treat prisoners who are at risk of suicide. That's the way it happens...Although we call ourselves policy-makers, really we're very much resourced to deal with incidents...We have annual planning exercises where we think about what we're supposed to be doing and what we will be doing. We set objectives...That all goes on, but the process at the end of day is that we spend so much of our time firefighting. The sort of blue skies type approach, you know, what shall we do to improve the position of drugs next? It doesn't develop like that. We need a few deaths or [something] to go completely haywire before anything gets done or someone to jump in there and say,

¹Interview (024) with penal reformer, January 1998

It is within this context that the 1995 prison drugs strategy revolved around the results of MDT as an indicator of its success or failure. The managerialist trend has been paralleled by the growing punitive rhetoric in penal policy. Within the managerialist dominated framework, MDT produced tangible, 'objective' results very quickly, providing it with much appeal to policy-makers and politicians. Furthermore, MDT was attractive because it gave the impression of 'taking control' of the drug problem in prisons by punishing drug misusers. Sanctions could be applied immediately to those who tested positive. Drug testing became a mechanism for managing and classifying prisoners into a risk group (Feeley and Simon, 1992). In comparison, it is much more difficult to assess the individual effects of treatment and rehabilitation. This would involve greater subjectivity and longer time periods to produce results.

The *proximate context* of prison drugs policy includes developments in both drugs and penal policy. However, in the first two phases of policy development, these two policy areas developed separately with very little overlap. Prisons generally remained on the periphery of drugs policy debates, while drugs remained on the periphery of penal policy debates. During the first phases, prison drugs policy was relatively insulated from developments in wider penal and drugs policy. By the early 1990s however, the interface between these two policy areas became much more explicit and visible.

Penal policy and the prison environment have generally acted as constraints on the development of liberal, pragmatic and progressive drugs policies. For example, the enduring penal 'crisis' characterised by an increasing population, overcrowding, riots, industrial disputes, lack of resources, and inadequate conditions has limited what can be proposed and achieved within policy development. Particularly in the early phases of policy, drugs were kept hidden as they were functional as mechanisms of control within this penal context. The collapse of the rehabilitative ideal and the move towards a just deserts, punishment and law and order framework also helped to curtail the development of drug treatment provision. Early attempts at drugs and HIV policy development were

²Interview (012) with civil servant, November 1997

further hindered by implementation which was strongly localised. By 1993, penal policy had begun to influence the direction of drugs policy in prisons with Michael Howard's pronouncement that 'prison works', his commitment to tackling the drug problem, and the influence of the Larmont recommendations. Prison drugs policy began to focus more closely on security, control and punishment, taking on the attributes of the austere and punitive penal policies which were emerging during this period. In contrast to developments in treatment provision, the MDT procedures and Larmont recommendations were universal requirements and this ensured that they were implemented across the entire penal system.

During the first two phases, prisons were generally excluded from developments and innovations in drugs policy. There were different discourses operating outside and inside the prison walls. During the first phase, the re-definition of drug addiction and the expansion of service provision in the community were not paralleled within the prison environment. The new partnership structures (DDACs) and the 1985 national drugs strategy omitted prisons from their remits. This began to change with the HIV/AIDS crisis when drug issues in the prison system moved into mainstream drugs policy debates. However, the new harm reduction principles and techniques which were operating successfully in the community failed to fully penetrate the development of HIV and drugs policies in prison. The constraints of the institutional context and the concern around the public imagery of such 'soft' policies meant that these principles were greatly modified and adapted within the prison environment. Under the 1995 national drugs strategy, there was a clear interface between penal and drugs policy. For the first time, prison-related aims and objectives were incorporated into policy at the national level and the Prison Service was expected to become involved in local and national partnership structures. The national strategy placed greater emphasis on enforcement, control and punishment and this paralleled the new punitiveness which was being advocated within penal policy. These two policy discourses had a profound effect on how the 1995 prison drugs strategy developed. Under the 1998 drugs strategy, the increasing focus on the link between drugs and crime will ensure that the interface between these two policy areas intensifies.

As discussed above, the *internal context* of prison drugs policy has been affected by changes in the membership and organisation of policy networks and structures. The framing of drugs policy issues in prison and the activities of policy networks have occurred within these nested contexts. When features within these contexts have shifted, it has produced a ripple effect often leading to the reframing of issues and renaming of the policy terrain. The policy networks have adapted and changed in response to these shifting contexts and terrains. The shifts have provided opportunities for policy networks to influence the policy process, but have also set the limits to their activities. The reverse process has also occurred whereby the reframing of prison drug issues has shaped the contexts. This can be seen in the policies and structures developed by the Conservatives which were then inherited by the Labour government. This policy feedback mechanism has set the parameters for subsequent policy development, often limiting and constraining what can be achieved.

The future of policy networks and prison drugs policy

The 'problem' of drugs in prisons has shifted from being a relatively obscure policy issue to a mainstream one which reoccurs on the policy agenda. Over time, drug issues within the prison system have become fully institutionalised in governmental policies and bureaucracies. The current phase of policy continues to develop and evolve. Interest in this area continues to increase and expand. For example, the Home Affairs Select Committee recently undertook an inquiry specifically to explore drug issues within prisons, the report of which was published in November 1999 (Home Affairs Committee, 1999). In the future, prison drugs policy will continue to be influenced by wider contexts and processes. New Labour's rhetoric of 'joined up' problems needing 'joined up' solutions provides new emphasis to the principles of partnership and multi-agency working. Within this framework, members of policy networks should become more knowledgeable about other policy areas, bringing these experiences and ideas to the prison drugs policy arena. There is also evidence that the reverse process is occurring whereby the emerging context and experience of prison drugs policy is influencing wider

policy frameworks. This can be seen in the expansion of drug testing into other spheres of policy, such as community penalties and policing, and the greater acceptance by practitioners of coerced treatment.

Although much research was ignored during the Conservative governments, there is now a new commitment to research and evidence. Within this 'new world', criminologists are wanted, rather than ignored. Joanna Shapland (1999) questions whether researchers are ready for this challenge. For example, this shift raises important ethical concerns which need to be carefully considered, such as the impact of research on 'subjects' and communities. It also prompts questions as to how far researchers are prepared to extend their role in terms of policy advice and advocacy. In the case of prison drugs policy, they have not occupied core roles in policy networks. Researchers have traditionally taken an 'objective' stance on their findings which are presented as information to policy-makers and used by others to influence the policy process (Brownstein, 1998). Their responsibility has not normally extended beyond producing and presenting reliable and valid results. Given their knowledge and ability to interpret findings, researchers can make valuable contributions by participating in the policy process through disseminating their findings widely and summarising their conclusions in the form of policy recommendations. Moreover, as Brownstein (1998: 6) argues, researchers could make their greatest contribution in the early stages of the policy process by framing and defining problems on the basis of research and evidence, rather than being relegated to the later stages of monitoring and evaluation. Policy analysis itself could also play important roles in the future development of policy. By studying policy networks, we can better understand the dynamics and contradictions within policy-making. As Edwards (1990: 30) argues, 'what needs to be more firmly acknowledged is that policy analysis focused on drug dependency issues is becoming a necessary tool for further policy development, rather than its being seen as mere academic diversion'.

This policy analysis has illustrated the movement towards a more refined and explicit prison drugs policy. This increasing clarity has been accompanied by a growing contradiction between treatment and punishment. Within prison drugs policy development, contradictory discourses and strategies have co-existed. There are

overlapping systems of regulation including treatment and care and punishment and control. Particularly in the early phases of policy development, many prisoners were serving time for drug offences or offences relating to problematic drug misuse, but were denied access to appropriate care and treatment. In the most recent phases, new techniques have been devised to punish drug misusers for their drugs use within the prison environment, while at the same time, they are offered new modes of treatment and rehabilitation. Similar to other areas of social policy (see MacGregor, 1999b), the bifurcation within prison drugs policy has become increasingly polarised. The practice of putting forward 'soft' and 'hard' approaches simultaneously within drugs and penal policy has become a potent theme. For prisoners who conform to the new regulations, tests and mechanisms of control, there is prevention, treatment and rehabilitation, as well as new incentives and privileges. For those who do not conform, there is increased surveillance, punishment and harsh treatment. At the same time, these contradictions are converging and becoming blurred. This can be seen in the greater acceptance of coerced treatment and so-called 'voluntary' drug testing. Over the various phases, the policy networks around drug issues in prisons have been influential in their attempts to contain and reconcile these contradictions between treatment and punishment. In the process however, a core part of the policy networks, namely the drug agencies, have been incorporated into this contradictory and converging policy framework. The key danger for the future development of policy is that these agencies will lose their independence and ability to contain the contradictions, to criticise existing policy, and to lobby for reform. Given the industry which is being developed around drug testing and treatment in the prison system, the diversion of drug misusers from custody is unlikely to be the ultimate goal for many of those involved in future policy networks.

Table A.1: All drug addicts (1) notified to the Home Office by prison medical officers by addict status 1981-1996

	New drug addicts (2)	% of all notifications (3)	Renotified drug addicts (4)	% of all notifications	All drug addicts notified	% of all notifications
1981 (5)	320	14	--	--	--	--
1982	322	12	--	--	--	--
1983	472	11	--	--	--	--
1984	819	15	--	--	--	--
1985	1138	18	--	--	--	--
1986	1102	21	--	--	--	--
1987	685	15	653	11	1338	12
1988	689	13	622	9	1311	10
1989	624	11	535	6	1159	8
1990	730	11	690	6	1420	8
1991	955	12	792	6	1747	8
1992	1268	13	1318	9	2586	10
1993	1941	17	1823	11	3764	13
1994	2080	15	1843	9	3923	12
1995	2602	18	2464	11	5066	14
1996	3665	20	3269	13	6934	16

Sources: Home Office Statistical Bulletins, Issues 6/92, 15/93, 10/94, 17/95, 15/96, 22/97, "Statistics of Drug Addicts Notified to the Home Office, United Kingdom, Tables 8a and 8b.

1. The statistics relate to notifications under the Misuse of Drugs Regulations 1973, which required doctors up until 30 April 1997 to send the details of people they considered to have been addicted to any of the following 14 controlled drugs to the Chief Medical Officer at the Home Office: cocaine, dextromoramide, diamorphine (heroin), dipipanone (Diconal), hydrocodone, hydromorphone, levorphanol, methadone (Physeptone), morphine, opium, oxycodone, pethidine, phenazone, and piritramide.

2. New addicts are those who have been notified for the first time.

3. The other sources of notifications include general medical practitioners, police surgeons, and hospitals/treatment centres.

4. Renotified addicts are those who have been notified in a previous year and who have again been notified in the current year. Full data on renotified addicts are available for the years 1987 onwards.

5. Data on notifications by prison medical officers is only available for the years 1981 onwards.

Table A.2 Drug offenders and custodial sentences 1980-1997

Year	Number of persons (1) found guilty, cautioned or dealt with by compounding (2) for drugs offences (3)	Number sentenced to immediate custody (4)	% (5)	Average sentence length (months) (6)
1980	17,158	1,676	10	15.8
1981	17,921	1,931	11	17.0
1982	20,356	2,248	11	15.4
1983	23,442	2,819	12	17.9
1984	25,240	3,694	15	18.8
1985	26,958	4,535	17	19.2
1986	23,905	3,928	16	19.8
1987	26,278	3,939	15	20.9
1988	30,515	3,523	12	21.3
1989	38,415	3,855	10	23.6
1990	44,922	3,402	8	23.9
1991	47,616	3,268	7	21.6
1992	48,927	3,366	7	24.0
1993	68,480	4,835	7	23.3
1994	85,691	5,596	7	20.8
1995	93,631	7,086	8	21.1
1996	95,010	8,788	9	21.2
1997	113,154	10,422	9	22.9

Source: Home Office Statistical Bulletins, Issues 18/84, 25/88, 10/98, 8/99, "Statistics of Drugs Seizures and Offenders Dealt With. United Kingdom".

1. As the same person may be found guilty, cautioned or dealt with by compounding for more than one drugs offence, rows cannot be added together to produce sub-totals or totals.

2. Compounding is a penalty which involves payment of a compound settlement in lieu of prosecution for minor personal use drugs offences.

3. Drug offences include unlawful possession and trafficking (unlawful production of drugs other than cannabis, unlawful supply, possession with intent to supply unlawfully and unlawful import and export).

4. Unsuspended imprisonment, partly suspended sentences, youth custody, detention centre sentences, training school orders, and young offender institute sentences.

5. This percentage is arrived at by dividing the total number given a sentence of immediate custody by the total number of persons found guilty, cautioned or dealt with by compounding for drugs offences.

6. In the case of offenders with two or more sentences of immediate custody, the offender is shown against the longest sentence except for Customs cases for 1989 onwards when consecutive sentences were aggregated.

Table A.3: Number of new and renotified drug addicts (1) notified to the Home Office and percentages addicted to heroin 1980-1996 (2)

	New drug addicts (3)	% addicted to heroin	Renotified drug addicts (4)	% addicted to heroin	All drug addicts notified	% addicted to heroin
1980	1,600	72 (n=1151)	--	--	--	--
1981	2,248	74 (n=1660)	--	--	--	--
1982	2,793	76 (n=2117)	--	--	--	--
1983	4,186	66 (n=3559)	--	--	--	--
1984	5,415	91 (n=4926)	--	--	--	--
1985	6,409	93 (n=5930)	--	--	--	--
1986	5,325	91 (n=4855)	--	--	--	--
1987	4,593	89 (n=4082)	6,123	83 (n=5101)	10,716	86
1988	5,212	89 (n=4630)	7,432	83 (n=6178)	12,644	85
1989	5,639	87 (n=4883)	9,146	83 (n=7601)	14,785	84
1990	6,923	84 (n=5819) (5)	10,832	80 (n=8678) (6)	17,755	82
1991	8,007	79 (n=6328)	12813	68 (n=8758)	20,820	72
1992	9,663	79 (n=7658)	15,040	62 (n=9306)	24,703	69
1993	11,561	78 (n=9063)	16,415	60 (n=9856)	27,976	68
1994	13,469	78 (n=10,607)	20,483	57 (n=11,706)	33,952	66
1995	14,735	79 (n=11620)	22,429	58 (n=12,910)	37,164	66
1996	18,281	84 (n=15271)	25,091	61 (n=15,302)	43,372	70

Sources: Home Office Statistical Bulletins, Issues 18/83, 25/88, 6/92, 10/94, 17/95, 15/96, 22/97, "Statistics of Drug Addicts Notified to the Home Office, United Kingdom".

1. The statistics relate to notifications under the Misuse of Drugs Regulations 1973, which required doctors up until 30 April 1997 to send the details of people they considered to have been addicted to any of the following 14 controlled drugs to the Chief Medical Officer at the Home Office: cocaine, dextromoramide, diamorphine (heroin), dipipanone (Diconal), hydrocodone, hydromorphone, levorphanol, methadone (Physeptone), morphine, opium, oxycodone, pethidine, phenazone, and piritramide.

2. Heroin addicts can be addicted to other drugs.

3. New addicts are those who have been notified for the first time.

4. Renotified addicts are those who have been notified in a previous year and who have again been notified in the current year. Full data on renotified addicts are available for the years 1987 onwards.

5. The number of new addicts reported to be addicted to heroin only was 4,475 in 1990; 4,727 in 1991; 5,839 in 1992; 6,759 in 1993; 7,852 in 1994; 8,507 in 1995; and 11,893 in 1996.

6. The number of renotified addicts reported to be addicted to heroin only was 6,240 in 1990; 6123 in 1991; 6601 in 1992; 6503 in 1993; 7,536 in 1994; 8,147 in 1995; and 9,842 in 1996.

Table B.1: Annual average (1) population in Prison Service establishments in England and Wales by sex 1975-1998

YEAR	MALES	FEMALES	TOTAL
1975	36,601	1,219	37,820
1976	40,161	1,282	41,443
1977	40,212	1,358	41,570
1978	40,409	1,387	41,796
1979	40,762	1,458	42,220
1980	40,748	1,516	42,264
1981	41,904	1,407	43,311
1982	42,381	1,326	43,707
1983	42,072	1,390	43,462
1984	41,822	1,473	43,295
1985	44,701	1,532	46,233
1986	45,163	1,607	46,770
1987	46,722	1,704	48,426
1988	47,113	1,759	48,872
1989	46,736	1,764	48,500
1990	43,378	1,597	44,975
1991	43,250	1,559	44,809
1992	43,157	1,562	44,719
1993	42,991	1,561	44,552
1994	46,810	1,811	48,621
1995	48,983	1,979	50,962
1996	53,019	2,262	55,281
1997	58,439	2,675	61,114
1998	62,194	3,105	65,299

Sources: Home Office, *Prison Statistics, England and Wales 1985, 1989, 1992, 1994*; Home Office Statistical Bulletin (1998) *The Prison Population in 1997 Issue 5/98*; Home Office (1999) *Prison Population Brief: England and Wales May 1999*.

1. Figures on the prison population are based on counts of prisoners at Prison Service establishments. These counts are usually made on the last day of the month. The annual average population is an average for the monthly returns.



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Date

Respondent's Address

Dear XXXX

I am currently conducting research on the development of prisons drugs policy. It is an independent piece of research for my doctoral dissertation with no funding body involved. The project is under the direction of Professor Susanne MacGregor.

The purpose of the research is to explore the processes involved in the development, formulation and implementation of prison drugs policy and its relationship to the national drugs strategy, Tackling Drugs Together.

I am in the process of interviewing a wide range of professionals within policy-making, drug agencies, penal reform groups and professional associations. I would very much like to interview you as part of this research.

The interview would last approximately 45 to 60 minutes. The format will be a free ranging discussion around a set of core questions. The interview will be wholly confidential and treated anonymously in all written material.

I would be extremely grateful if you could contact me regarding the research and the interview. I can be contacted on 0181-362-6424 or 0181-445-6283 (both numbers have ansaphones).

I appreciate your attention in this matter and look forward to hearing from you.

Yours sincerely

Karen Duke
RESEARCH FELLOW



Interview Schedule

Core Questions/Issues

Since the early 1990s, there appears to be increased interest around the issues of drug misuse and prisons. Why do you think there has been this increased interest?

Why do you think prison-related aims and objectives were incorporated into the 1995 national drugs strategy for the first time?

How do you see the drugs ‘problem’ in relation to prisons? (examples/illustrations)

In your view, how is the ‘problem’ being addressed? (examples/illustrations)

Why do you think the ‘problem’ is being addressed in this way?

Do you think this response has been effective? Why/why not? (examples/illustrations)

What type of response would be more effective? (examples/illustrations?)

Do you think there is a balance between treatment and enforcement measures in the prison drugs strategy? If yes, how is this balance achieved? If no, why not?

What is the value of the partnership approach as applied to drugs and prison? At the national level? Local level? What are the problems with applying the partnership approach to the issues of drugs and prison? How are these dealt with?

How have the new players influenced the direction of policy, and in particular, the Prison Service?

Key issues for the future in terms of drugs policy and prisons

APPENDIX C



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Respondent's Address

Dear XXXX

I would like to take this opportunity to thank you for your help and co-operation with my research on the development of prison drugs policy. I am very grateful that you agreed to be interviewed. Your contribution will be extremely useful to my analysis.

I would also like to stress again that the interview is wholly confidential and will be treated anonymously in all written material.

Yours sincerely

Karen Duke
RESEARCH FELLOW



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